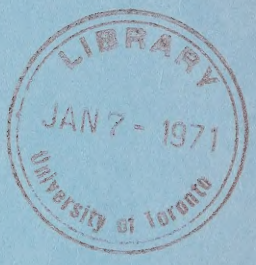
HEALTH AND WELFARE SERVICES

IN CANADA

1970



A publication of the Department of National Health and Welfare, Canada

HEALTH AND WELFARE SERVICES IN CANADA

1970

Research and Statistics Directorate

Published by authority of
the Honourable John Munro
Minister of National Health and Welfare

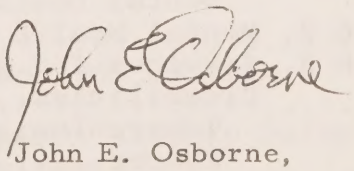
J. Maurice LeClair, M.D.,
Deputy Minister of National Health

Joseph W. Willard,
Deputy Minister of National Welfare

FOREWORD

This book gathers together for ready reference brief descriptions of arrangements made for the provision of health and welfare services to Canadians, resumés of recent events in the evolution of those arrangements, and pertinent statistics of their operation. Most of the contents were prepared by the Research and Statistics Directorate of the Department of National Health and Welfare for the chapter, "Health, Welfare and Social Security" of the 1970-1971 Canada Year Book. Certain other material is included here that for brevity was omitted from that chapter.

The Directorate is indebted to many officers of the Department for contributing to various passages; the other sections were prepared by the staff of the Directorate. The editor was Mr. Arthur F. Smith.



John E. Osborne,
Director,
Research and Statistics.

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IN CANADA

INTRODUCTION

Among the significant developments in the period January 1969 to June 1970 was the completion of the Task Force Reports on the Cost of Health Services in Canada. These reports contain almost 400 recommendations on methods to restrain the rate of increase in health service costs while maintaining and improving the quality of care. Many of these recommendations will be implemented by the federal and provincial health departments.

Since the July 1, 1968 inception of the federal Medical Care Insurance Program, in which Saskatchewan and British Columbia were the original participating provinces, five more provinces have entered the plan. They are Manitoba, Newfoundland, Nova Scotia, Alberta and Ontario. The three other provinces were reported planning to enter by the end of 1970.

Because of increasing concern over the detrimental effects of D.D.T. on the environment and its potential hazard to health, the Food and Drug Directorate has restricted the use of this chemical. This move is intended to reduce the residue level and improve the environment for fish and game as well as humans. The use of cyclamates in beverages, dietetic desserts, paediatric drugs, and dietetic canned fruits is being phased out due to their possible carcinogenic properties. The use of cyclamates will be allowed only under close medical supervision.

The growing problem of environmental pollution has resulted in a number of activities by the Department. One of the most significant is the national Standards for Drinking Water Quality. These standards will assist provincial and municipal authorities in providing greater protection for drinking-water supplies. An Air Pollution Control Division has been formed in the Department to monitor air pollution and to set standards for emission of pollutants.

Activity to reduce the smoking of tobacco products by Canadians continued. Information, advertisements, and legislative proposals have been developed by the Department to make citizens aware of the dangers of smoking and to reduce the number of children taking up smoking. Publication of the tar and nicotine content of various brands of cigarettes was one of the most significant events to date. Legislative proposals made

in 1968 regarding advertising and levels for tars and nicotine are still being considered.

A survey of radiation from colour television sets has resulted in the preparation of legislation for the control of radiation from all radiation-emitting appliances including television sets, lasers, microwave ovens, and microwave dryers.

The interim report of the Commission of Inquiry into the Non-medical Use of Drugs was tabled. It recommends that research be continued into the social and pharmacological effects of marihuana and that adequate treatment facilities be provided for persons using drugs. The necessity of more information to be disseminated was stressed, and it was suggested that young people play a major role in drug education. It also recommended that the use of marihuana be controlled through the Food and Drugs Act rather than the Narcotic Control Act, and that there be certain changes in the handling of convictions.

The Department of National Health and Welfare will begin a National Survey of Nutrition in September 1970. A trial survey has already been undertaken in Burlington, Ontario. The objective of the survey is to provide basic information on the nutritional well-being of Canadians for the planning of public health programs, and for the development of the Food and Drug regulations. It will estimate the incidence of nutritional diseases and disorders in groups of the Canadian population, characterized by such factors as geographical location, type of community, income level, and the age and sex of individuals. It will also identify the types of foods and estimate the quantity normally ingested by individuals in order to determine the levels of ingestion of nutrients, food additives, non-nutritive substances and pesticide residues.

In 1969 the National Council of Welfare, an advisory body to the Minister of National Health and Welfare, was reconstituted as a citizens' advisory council. Representatives of low-income or disadvantaged minority-group organizations comprise almost half the membership of this Council. A Division has been established within the Department to act as a secretariat for the Council and to provide a continuing liaison between it and these low income groups.

The federal-provincial Task Force on a Developmental Approach to Public Assistance, the federal-provincial Working Group on Costs of Welfare Programs, and the Study Group on Alienation, established by the federal-provincial Conference of Ministers of Welfare early in 1969, continued their work. The Study Group on Alienation has conducted an extensive program of

research on a nation-wide basis as well as in particular provinces to determine the alienating factors in the welfare system, to experiment with structures that could overcome these alienating factors, and to recommend remedial action on the part of the welfare ministers.

The Department of National Health and Welfare submitted a brief to the Special Senate Committee on Poverty, chaired by Senator Croll, in February 1970. The brief describes the Department's policies against poverty and its role in providing services, or assisting in the provision of services, for the population as a whole as well as especially vulnerable groups.

Old Age Security pensions were increased two per cent, again, as the Consumer Price Index showed a continued rise. The pension rose to $79.58 per month in 1970. Combined with the Guaranteed Income Supplement, monthly payments total $111.41 per pensioner. Benefits are now available at age 65 compared to age 66 in 1969; the year-by-year progressive reduction of the age of pension availability is now complete.

Under the Canada and Quebec Pension Plans benefits have become available to persons retiring at age 65 or over. These benefits have been increased to a maximum of just under $48 per month as of June 1970. Survivors', dependents', and disability pensions have also been increased. As of December 1969 about 170,000 persons were receiving benefits under the Canada and Quebec Pension Plans.

Work is now underway in the Department of National Health and Welfare on a White Paper on Income Security, dealing with programs for low income and disadvantaged persons in Canada. The White Paper is expected to be issued in late 1970.

PART I - PUBLIC HEALTH

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The federal government has jurisdiction over a number of health matters of a national character and provides important financial assistance to provincial health and hospital services. All levels of government are aided and supported by a network of voluntary agencies working in different health fields.

Section 1 - Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters but important treatment programs are also administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for collection, analysis, and publication of national health statistics, the Medical Research Council and the Defence Research Board administer medical research programs, and the Canada Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare has both a direct role in health activities and a supportive role to the provinces. Direct health care activities are concentrated mainly in the Medical Services Branch of the Department, which provides health services to Indians and Eskimos, operates quarantine and immigration medical services, administers the civil aviation medical program for the Department of Transport, and provides medical counselling and emergency medical service to federal civil servants. The Food and Drug Directorate is also actively involved in health care by maintaining surveillance over the manufacture, advertising, packaging, and distribution of foods, drugs, cosmetics, and medical devices as well as performing research in respect to standards for these items.

Advisory services, co-ordination of programs, and liaison activities with the provinces are provided by the Health Services Branch in the areas of child and maternal health, dental health, epidemiology, mental health, nutrition, health education, smoking and health, rehabilitation, and emergency health services. Standards are also set in this Branch for clinical

laboratory services, biological products, levels for radiation, and environmental pollution. Financial support to the provinces on a cost sharing basis for hospital and medical insurance and health resources is provided by the Health Insurance and Resources Branch.

Subsection 1 - Food and Drug Control

The provisions of the Food and Drugs Act, administered by the Food and Drug Directorate of the Department of National Health and Welfare, apply to the manufacture, advertising, packaging, and distribution of foods, drugs, cosmetics, and medical devices anywhere in Canada. Powers are given under this legislation to maintain the safety, purity, and quality of food and drug products and to prevent misrepresentation in labelling and advertising. The Act specifically prohibits the advertising of any food, drug, cosmetic, or medical device as a preventive or cure for a number of serious diseases. This feature of the Act is thought to be unique to Canada and it has proven valuable in the prevention of fraud.

Standards of safety and purity are developed through laboratory research and maintained by means of a regular and widespread inspection. The inspection of food-manufacturing establishments plays a major role in the production of clean, wholesome foods containing ingredients that meet recognized standards. Changing food technology requires the development of methods of laboratory analysis to ensure the safety of new types of ingredients and packaging materials. The Food and Drug Regulations list chemical additives that may be used in foods, the amounts that may be added to each food, and the underlying reason. Information on new additives must be submitted for careful review before they are added to the permitted list. Considerable emphasis is placed upon studies to ensure that the levels of pesticide residues in foods do not constitute a health hazard. The effect of new packaging and processing techniques on the bacteria associated with food spoilage is also of special concern.

The Food and Drug Directorate regulate both the manufacture and distribution of drugs in Canada. The conditions under which drugs are to be manufactured are described in the Manufacturing Facilities and Control regulations. They relate to facilities, employment of qualified personnel, quality control procedures, maintenance of records, and a suitable system to enable a complete and rapid recall of any batch of drugs from the market.

Pharmaceutical plants are regularly visited by inspectors to ensure that the drugs produced are of a suitable quality to be sold in Canada.

The control over the distribution of drugs is based on the relative safety of a drug and its potential for abuse. Accordingly, there are different levels of control. Since 1966, every manufacturer and distributor of drugs in Canada is required to submit to the Food and Drug Directorate information on all the products he is marketing in Canada. From this and other information decisions are made regarding the types of control procedure that will be implemented.

A limited number of drugs in specified dosage ranges may be sold through any outlet under the Patent and Proprietary Medicines Act. Registration under this Act allows a manufacturer to sell secret formula preparations and make limited claims for the product. The majority of drug products, however, are limited to sale on prescription and are usually dispensed to patients through a pharmacy. Narcotics and controlled drugs are closely regulated and detailed records kept of all transactions involved in the legitimate use of these products. The illicit market in narcotics and similar products is the responsibility of the Royal Canadian Mounted Police, and other law-enforcement agencies. Close co-operation is maintained between these agencies and the Food and Drug Directorate.

When new drugs with unknown properties are to be placed on the market detailed information is demanded of the manufacturer. This information includes data on adverse side effects, the manufacturing process to be used, the results of the drug in clinical tests, and the formulation of the dosage forms. The data are carefully reviewed by the Directorate to ensure that the drug is safe and that it is effective for the purpose claimed. Even after the drug is marketed the Food and Drug Directorate maintain a close watch over the side effects encountered in practice. If it proves to be relatively safe and effective it is no longer classed as a new drug, but if it appears that it may be unsafe the manufacturer would be asked to remove it from the market.

The Directorate conduct an adverse-drug-reaction reporting program across Canada to recognize and investigate reactions to drugs. The co-operation of the medical, dental, veterinary, and pharmaceutical professions is also solicited in advising the Directorate of such reactions in private practice.

Subsection 2 - Medical Services

Through its Medical Services Branch, the Department of National Health and Welfare provides several direct and indirect types of medical service, as described in the following paragraphs. "Indirect" services are provided by hiring local services where practicable.

Indians and Eskimos. - Medical and public-health services are made available to registered Indians or Eskimos who are not included under provincial arrangements and who are unable to provide for themselves. Much of the service in treatment and health education is rendered to the patients through 46 departmental out-patient clinics and 91 health centres staffed by medical and other public health personnel. In remote areas, the key facility is frequently the departmental nursing station, a combined emergency treatment and public health unit usually having two to four beds under the direction of one or two nurses; 57 of these are operated throughout Canada.

Where practicable, there has been considerable integration of Indians in provincial and municipal health agencies, so that the number of hospitals and other facilities provided specifically for them have been reduced accordingly. At present the Department maintains 13 hospitals at strategic points and co-operates elsewhere with community, mission, or company hospitals. Indians are included under all provincial prepaid insurance plans for hospital care and other forms of insured medical care. Indian and Eskimo health workers are trained to give instruction in health care and sanitation.

Northern health. - Because of the special problems in developing health services in the Far North, the Department has been given the responsibility of co-ordinating federal and territorial health care for all residents. In so doing, it undertakes the functions of a health department for the Council of the Northwest Territories and assists the government of the Yukon in the provision of certain health services. Hospital insurance plans are in effect in both territories.

In the Yukon, services for the total population, administered through the Commissioner for the Yukon and provided on a cost-sharing basis with the Department of National Health and Welfare, include complete treatment for tuberculosis, payment for services rendered at the Alberta cancer clinics, mental hospital care through arrangements with the province of British Columbia, and medical care for indigent patients.

Public-health nursing services, measures for the control of communicable diseases, and administration of the principal public hospital are primarily the responsibility of the Department.

Similar services are provided in the Northwest Territories with costs shared between the territorial government and the Departments of National Health and Welfare and of Indian Affairs and Northern Development.

Sick mariners. - As of mid-1970, the Department provides compulsorily prepaid medical, surgical, hospital, and other treatment services to crew members of all foreign-going ships arriving in Canada and Canadian coastal vessels in interprovincial trade, and offers medical, surgical, and other treatment prepayment on an elective basis to crew members of Canadian fishing vessels. (Canadian seamen obtain their hospital care under the provincial hospital insurance plans.)

Quarantine. - Under the Quarantine Act, all vessels, aircraft, and other conveyances and their crew and passengers arriving in Canada from foreign countries are inspected by quarantine officers to detect and correct conditions that could lead to the entry into Canada of such diseases as smallpox, cholera, plague, yellowfever, typhus, and relapsing fever. Fully organized quarantine stations are located at all major seaports and airports.

Immigration. - Under the Immigration Act and the Department of National Health and Welfare Act, the Immigration Medical Service conducts in Canada and other countries the medical examination of all applicants for immigration to Canada and provides treatment for certain classes of persons after arrival in Canada, including immigrants who become ill en route to their destination or while seeking employment.

Public service health counselling. - Health counselling is offered through Medical Services Branch units to federal employees throughout the country. This service is primarily diagnostic and advisory only, but emergency treatment may also be given.

Civil aviation medical assessment service. - Air pilots and other air personnel are routinely examined by this service for physical and mental fitness for the performance of their duties.

Regulation of hygienic standards. - The Department is responsible for enforcing hygienic standards on federal property including ports and terminals, interprovincial means of transport, and on Canadian ships and aircraft.

Coast Guard medical service. - The Department provides a medical service for the Canadian Coast Guard.

Subsection 3 - Medical Research

Federal government expenditures for health sciences research are estimated at $58.5 million for 1969-70. This is a substantial increase from the expenditure of $44.7 million in 1967-68. The expenditures are almost totally accounted for between the Medical Research Council, $30.9 million, and the Department of National Health and Welfare, $27.1.

Federal grants supporting the development of health sciences research and research personnel in universities and hospitals have been channelled mainly through the Medical Research Council, although significant outlays are made by other agencies in special fields such as public health, health care systems, and defence. The Medical Research Council spent $30.9 million in 1969-70 of which $12,051,000 was allocated for annual grants-in-aid, $6,875,500 for three-year term research projects, $1,844,000 for equipment grants, $7,718,000 for research scholarships and fellowships, and $2,402,000 for other research promotion. These data include dental and pharmaceutical research which had formerly received assistance through the National Research Council; pharmacy research assistance was included in the 1968-69 M.R.C. expenditures and both pharmacy and dental research were included in 1969-70. These changes were part of the change by which the Medical Research Council became an autonomous group which reports to parliament through the Minister of National Health and Welfare. Before April 1st, 1969 it was part of the National Research Council.

The Department of National Health and Welfare accounted for the greatest amount of intramural expenditures, $8.8 million, on research and development studies and related scientific activities. The major fields in which research was performed were environmental health, pharmacology, nutrition, microbiology, pesticides, food additives, clinical laboratory procedures, radiation protection, health services, prosthetics, epidemiology, and physical fitness. The Department of Veterans Affairs support a variety of clinical studies

in chronic disease problems including psychiatric research. This research totalled $457,000 in 1969-70. Studies in radiation biology and other life sciences important to health are conducted by the National Research Council.

The Department of National Health and Welfare in 1969-70 distributed $4.4 million under the Public Health Research Grant for applied and developmental research projects conducted by universities, hospitals, health departments, and other nonprofit health organizations. A further $1,062,000 was provided under the newly established National Health Grant. In addition, the Department gave $143,000 for physiological research under the Fitness and Amateur Sport Grant, and $61,000 for smoking and health research. The expansion of research facilities continues to be one of the key objectives of the Health Resources Program of the Department of National Health and Welfare. It is estimated that $13 million or 40 per cent of the Health Resources Fund expenditures in 1969-70 were used to build research facilities as an integral part of the program to expand the training of health personnel at medical and dental schools and affiliated centres.

The principal voluntary agencies supporting medical research in Canada, related to their special interests, are the National Cancer Institute, Canadian Arthritis and Rheumatism Society. The Interdepartmental Committee on Medical Research provides a forum for the sharing of information and support of medical research to which the voluntary agencies are invited.

Subsection 4 - Consultative and Technical Services

The Department of National Health and Welfare extends consultative and technical services to the provinces over a broad range of health activities. The consultant divisions of the Health Services Branch are concerned with the following areas: epidemiology including disease surveillance; communicable disease control as exemplified by the Canadian Communicable Disease Centre that serves as the national reference laboratory for diagnosis of bacterial and viral diseases; child and adult health including mental health, dental health and nutrition; and rehabilitation, emergency health and environmental health programs described elsewhere. The federal health department also provides technical advisory services to the provinces through its Health Insurance and Resources Branch. In addition, research and statistical services and health information in the form of literature, films and radio programs are supplied on a variety of subjects such as mental health and smoking.

Section 2 - Federal-Provincial Health Activities

The Department of National Health and Welfare serves the provinces in an advisory, technical, and co-ordinating capacity and administers grants to provincial and voluntary health agencies. Administration of federal aspects of the Health Resources Fund and of programs relating to hospital insurance, medical insurance, the Canada Assistance Plan, and National Health Grants is a major activity. Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health.

Subsection 1 - Medical Care

The expression "medicare" is commonly used in referring to the federal Medical Care Insurance Program. This program, established under the Medical Care Act*, has permitted the federal government, since July 1, 1968, to contribute half of the national cost of insured services to those provinces operating medical care insurance plans which meet certain minimum criteria.

Two provinces, British Columbia and Saskatchewan, became participants in the federal plan from its inception. Manitoba, Nova Scotia and Newfoundland entered on April 1, 1969, Alberta on July 1, and Ontario on October 1. It was anticipated that the three remaining provinces would enter the program by the end of 1970.

The federal government does not operate a medical care insurance plan as such or sell medical care insurance to individual families. These activities are within provincial jurisdiction. The Medical Care Program is essentially a grant-in-aid activity that the federal government introduced to assist the provinces in making it possible for all Canadians to have access to necessary medical care. The program is in some respects analogous to the national Hospital Insurance and Diagnostic Services Program, described elsewhere.

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*The administration of the Act in relation to the federal area of responsibility, is described in the first "Annual Report of the Minister of National Health and Welfare Respecting Operations of the Medical Care Act for the Fiscal Year Ended March 31, 1969".

Specifically, the federal government contributes to any one participating province half the per capita cost of all insured services furnished under the plans of all participating provinces, multiplied by the number of insured persons in that one province. The minimum criteria which must be met are the following.

(1) Comprehensive coverage must be provided for all medically required services rendered by a physician or surgeon. There can be no dollar limit or exclusion except on the ground that the service was not medically required. The federal program includes not only those services which have been traditionally covered as benefits to a greater or lesser extent by the health insurance industry, but also preventive and curative services which have been traditionally covered through the public sector in each province; for example, the medical care of patients in mental and tuberculosis hospitals and those services of a preventive nature provided to individuals by physicians in public health agencies.

(2) The plan must be universally available to all eligible residents on equal terms and conditions and must cover at least 90 per cent of the total eligible provincial population at the outset of the program and at least 95 per cent after April 1, 1971. This "uniform terms and conditions" clause is intended to ensure that all residents have access to coverage and to prevent discrimination in premiums on account of previous health, age, non-membership in a group, or other considerations. If a premium system of financing is selected, subsidization in whole or in part for low-income groups is permitted. It has been left to the individual province to determine whether its residents should be insured on a voluntary or compulsory basis. Utilization charges at the time of service are not precluded by the federal legislation if they do not impede, either by their amount or the manner of their application, reasonable access to necessary medical care, particularly for low income groups.

(3) The plan must provide portability of benefit coverage when the insured resident who has paid his premiums, if any, is temporarily absent from the province and when moving residence to another participating province.

(4) The provincial medical care insurance plan must be administered on a non-profit basis by a public authority that is accountable to the provincial government for its financial transactions. It is permissible for provinces to assign certain administrative functions to private agencies.

Provincial programs that provide health care services (apart from those which are already insured services under the Medical Care Act) for welfare recipients establishing eligibility on the basis of financial need are supported financially by the federal program known as the Canada Assistance Plan. This program, described elsewhere in detail, provides for federal payment of half the cost of personal health care services, as well as welfare services. The provinces are free to make available a wide range of health care benefits.

Subsection 2 - Health Resources Program

The Health Resources Program is concerned with manpower in the health fields necessary for the provision of comprehensive health services to Canadians. Under the program the Government of Canada provides capital grants for teaching and research establishments, undertakes studies on health manpower, and offers advice and consultation.

The capital-grant aspect of the program was inaugurated when in July 1966 Parliament passed the Health Resources Fund Act, which was established to develop resources for the training of personnel in order to reduce shortages and to meet the increase in demand that is likely to follow the introduction of medical-care insurance. The Act established a fund of 500 million dollars, available over the period 1966 to 1980. Out of this fund the Government will pay up to 50 per cent of the cost of planning, construction, purchase, renovation, and basic equipment of teaching hospitals, medical schools, training facilities for nurses and other health professionals, and research establishments; the costs of land, interest, and residential buildings are excluded. Of the 500 million dollars, 300 million are available to the provinces in proportion to their populations; another 25 million dollars are available to the Atlantic provinces for joint projects in which all the four provinces participate; while the remaining 175 million dollars are yet to be allocated. By March 31st, 1970, the Government had approved contributions of 160 million dollars and paid out 106 million. About two-thirds of these sums were for training facilities, and one-third for research establishments.

In 1969, the Department in conjunction with the Association of Universities and Colleges of Canada called a National Health Manpower Conference to secure agreement on guidelines for:

1. Planning the delivery of total health services during the next decade.

2. Determining the numbers and quality of the health manpower required for these services.

3. Planning the education of the required health manpower.

There was general agreement on the need for planning and co-ordinated efforts to achieve health objectives and to restrain the rapid increase in health care costs. Recommendations were made: for the establishment of planning groups, to relate the training of health professionals to the demand for their services, and to implement research into health care delivery systems.

The Department also provides technical and professional advice and consults with officials of provincial governments and other agencies who are concerned with the development of health resources in Canada, and supports programs to increase the effectiveness of health manpower. These activities are undertaken in order that the Health Resources Fund shall be used more economically and efficiently.

Subsection 3 - National Health Grant Program

The National Health Grant program was instituted in 1948 to assist the provinces in extending and improving public health and hospital services. As provincial needs altered, changes were made in the amounts and conditions of individual grants. Table 1 shows the utilization of the General Health Grants and Hospital Construction Grants and changes in their classification since inception, and the grants current in 1969-70, as follows: Professional Training, Hospital Construction, Mental Health, Tuberculosis Control, Public Health Research, General Public Health, Cancer Control, Medical Rehabilitation and Crippled Children, and Child and Maternal Health. During the period from 1948 to 1970, the total expenditures under this program were $900 million.

The largest single grant has been in support of hospital construction. This grant was terminated on March 31, 1970, and lump sum cash payments were made to the provinces and territories in discharge of the full entitlement of each province and territory to the termination date of the grant.

TABLE 1 - AMOUNTS ALLOCATED AND AMOUNTS AND PERCENTAGES EXPENDED UNDER THE GENERAL HEALTH GRANTS AND HOSPITAL CONSTRUCTION GRANTS, BY GRANT, FOR THE PERIOD ENDED MARCH 31, 1969, AND FOR THE YEAR ENDED MARCH 31, 1970

GRANT	May 14, 1948 - March 31, 1969			Year Ended March 31, 1970	
	Amount Allocated(a)	Amount Expended(b)	Percentage Expended	Amount Allocated(a)	Amount Expended(b,c)
	$	$		$	$
Crippled Children(d)	6,207,728	4,431,677	71	-	-
Professional Training	23,467,773	23,238,217	99	2,074,400	2,178,604
Hospital Construction(e)	313,521,092	280,830,235	92	20,367,320	44,167,029
Venereal Disease Control(f)	5,968,336	5,146,209	86	-	-
Mental Health	154,158,969	133,695,502	86	6,103,395	6,221,674
Tuberculosis Control	73,853,829	70,138,688	94	1,356,309	1,389,736
Public Health Research	32,416,408	28,820,176	88	4,771,120	3,941,955
Health Survey(g)	645,180	540,960	83	-	-
General Public Health	222,996,666	175,688,177	78	11,788,990	13,083,908
Cancer Control	68,030,367	50,220,603	73	1,356,309	1,172,001
Laboratory and Radiological Services(h)	47,404,300	14,450,881	30	-	-
Medical Rehabilitation(i)	6,500,000	3,016,750	46	-	-
Medical Rehabilitation and Crippled Children(j)	25,152,895	16,656,055	66	2,093,458	1,310,762
Child and Maternal Health(k)	27,897,194	19,345,240	69	1,356,309	700,760
TOTAL	1,008,220,737	826,219,370	81	51,267,610	74,166,429

(a) As set out in the Orders-in-Council authorizing the General Health Grants and Hospital Construction Grants for the years cited. Provinces may vary the amounts allocated for individual General Health Grants by transfer of unexpended funds from one Grant to another.
(b) Total expenditures for each Grant for all provinces including Quebec's share, which has been paid through tax rebate under the Established Programs (Interim Arrangements) Act, effective 1965-66.
(c) Because of transfer of funds between grants, expenditures can exceed amounts allocated.
(d) Merged with Medical Rehabilitation Grant, April 1, 1960.
(e) The amounts allocated exclude, whereas the amounts expended for 1969-70 include, revotes for unclaimed allocations as from April 1, 1953.
(f) Absorbed into the General Public Health Grant, April 1, 1960.
(g) Lapsed in 1953 following the completion of provincial health surveys.
(h) Introduced in 1953 and absorbed into the General Public Health Grant, April 1, 1960.
(i) Introduced in 1953 and merged with the Crippled Children Grant, April 1, 1960.
(j) Introduced in 1960 - see footnote d and i.
(k) Introduced in 1953.

During the life of this grant, funds were approved to assist with the construction of space to house more than 130,200 beds and 16,000 bassinets, for more than 24,300 beds for nurses, 971 beds for interns and more than 8,315,000 square feet of floor area for certain services used by both in-patients and out-patients. The second largest grant, the General Public Health Grant, has assisted the provinces in extending local health services to prevent disease and disability, in controlling environmental health hazards, and in developing a great variety of health services. Since 1948 more than 53,700 persons have received assistance in taking training in the health disciplines, either through short courses or by academic courses of a year or more. Other grants are designated for preventive and treatment services in specific areas, such as mental health, tuberculosis and cancer control, maternal and child health, and medical rehabilitation. Projects supported by the Public Health Research Grant relate to the prevention of disease, disability, or death; epidemiology; community-based health and medical care; operational research; environmental health, including sanitation; and the utilization of health manpower.

The Government has indicated its intention of terminating the General Health Grants, except for the Professional Training and Public Health Research grants, by the end of the 1971-72 fiscal year. To accomplish this, the amounts available to the provinces are being gradually reduced, with the first reduction having taken place in 1969-70 and the second in the 1970-71 fiscal year.

In April 1969 a new National Health Grant was established to stimulate research studies, service demonstrations, and training activities of national importance for the improvement of health services. Eligible applicants may be official or voluntary health agencies, universities, or other qualified agencies or individuals. In 1969-70, the amount allocated was $1,062,000 on the basis of five cents per capita of population; in 1970-71, it was increased to $2,300,000 on the basis of 10 cents per capita. Unlike its predecessor, which was a joint federal-provincial program, the National Health Grant is federally administered.

Subsection 4 - Hospital Insurance

Provincial hospital insurance programs, operating in all provinces and territories since 1961, cover 99 per cent of the population of Canada. Under the Hospital Insurance and

Diagnostic Services Act of 1957, the Federal Government shares with the provinces the cost of providing specified hospital services to insured patients. Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, and institutions providing custodial care, such as nursing homes and homes for the aged. The methods of administering and financing the program in each province and the provision of services above the stipulated minimum required by the Act are left to the choice of the province.

When the Act was passed in 1957, Newfoundland, Saskatchewan, Alberta, and British Columbia were already operating hospital insurance plans; those four provinces and Manitoba entered federal-provincial agreements on July 1, 1968, the earliest possible date under the new Act. Prince Edward Island, Nova Scotia, New Brunswick, and Ontario followed in 1959, the Territories in 1960, and Quebec in 1961.

Insured in-patient services must include accommodation, meals, necessary nursing service, diagnostic procedures, pharmaceuticals, the use of operating rooms, case rooms, and anaesthetic facilities, and the use of radiotherapy and physiotherapy if available. Similar out-patient services may be included in provincial plans and authorized for contribution under the Act. All provinces include some out-patient services, and most cover a fairly comprehensive range. Provincial plans are administered by the provincial department of health in some provinces and by a separate commission in others. To finance the insurance plans, the provinces use general revenue, sales taxes and premiums in various combinations.* The Government of Canada contributes out of the consolidated revenue fund in respect to each province the sum of 25 per cent of the per capita cost of in-patient services in Canada and 25 per cent of the per capita cost of in-patient services in the province, multiplied by the average number of insured people in that province. Contributions for insured out-patient services with respect to each province are paid in the same proportion as the contributions to the cost for in-patients. Since

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*All provinces use general revenue; Nova Scotia levies a health services tax; Ontario, Manitoba, and Saskatchewan impose premiums; Alberta levies a special tax on municipalities; and Saskatchewan, Alberta, British Columbia, and the Northwest Territories impose authorized charges at the time of service.

January 1st, 1965, contributions to Quebec under the Hospital Insurance and Diagnostic Services Act have been replaced by arrangements under the Established Programs (Interim Arrangements) Act.

Table 2 shows the proportion contributed by the Government of Canada towards the cost of insured hospital services in each province. It varies according to law around 50 per cent, and ranged in 1967 from 47 per cent for Ontario to 62 per cent for Prince Edward Island. Note that the lower the average cost per person is in a province, the greater the proportion which the province recovers from the central government.

Tables 3 to 12, unless otherwise stated, contain statistics on the hospitals that are listed in the federal-provincial hospital insurance agreements. Most of these are public general or special hospitals designated in the tables as "budget review" hospitals (hospitals whose budgets require approval by the provincial hospital authority). "Contract" hospitals are privately owned institutions that provide care to insured patients under contract with the provincial agency. Government of Canada hospitals are operated by the Departments of National Health and Welfare, Veterans Affairs, and National Defence.

Table 3 shows that 1,298 hospitals in Canada were listed in the federal-provincial agreements at the end of 1967. Table 4 shows that the total number of beds at the end of 1967 was 141,241, or 6.9 beds per thousand population. This ratio ranged from 5.9 in Prince Edward Island to 9.0 in Alberta and was still higher in the territories.

Table 5 shows patient-days in listed hospitals. The total, 41.0 million, corresponds to a rate of 2,007 patient-days per thousand population for Canada. The rate ranged from 1,574 in Newfoundland to 2,419 in Alberta.

Table 6 shows average length of hospital stay and occupancy ratios for budget review hospitals only. The average length of stay of patients who were discharged from or who died in general hospitals during 1967 (excluding the Territories), ranged from 8.9 days in Alberta to 11.1 days in Ontario; the average for Canada was 10.2 days. Length of stay in chronic hospitals was 186.9 days for Canada as a whole but there was considerable variation among the provinces. In convalescent hospitals, the average length of stay was 44.1 days.

TABLE 2 - PERCENTAGES OF THE COSTS OF INSURED HOSPITAL SERVICES CONTRIBUTED UNDER THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT, BY THE GOVERNMENT OF CANADA, 1966 TO 1969

Province	1966	1967	1968(a)	1969(a)
Newfoundland	56	56	52	57
Prince Edward Island	63	62	63	63
Nova Scotia	56	54	53	52
New Brunswick	53	52	52	51
Ontario	49	48	47	47
Manitoba	53	52	51	51
Saskatchewan	49	50	51	52
Alberta	47	47	50	50
British Columbia	53	53	52	52
Yukon	55	56	57	52
Northwest Territories	49	50	52	48

(a) preliminary

TABLE 3 - NUMBER OF HOSPITALS AND OTHER FACILITIES LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY STATUS, CANADA AND PROVINCES, DECEMBER 31st, 1967

Province	Hospitals				Other facilities(b)	Total
	Budget review	Contract(a)	Gov't of Canada	Total(a)		
Newfoundland	46	1	-	47	2	49
Prince Edward Island	9	-	-	9	1	10
Nova Scotia	47	-	1	48	2	50
New Brunswick	40	-	1	41	1	42
Quebec	177	81	11	269	6	275
Ontario	225	79	12	316	4	320
Manitoba	82	5	16	103	2	105
Saskatchewan	151	5	3	159	6	165
Alberta	142	2	8	152	20	172
British Columbia	102	13	5	120	1	121
Yukon	2	-	3	5	1	6
Northwest Territories	2	6	21	29	1	30
Canada	1,025	192	81	1,298	47	1,345

(a) Excludes the three hospitals in the U.S.A. near the Canadian border that are listed in the agreements with New Brunswick and Manitoba.

(b) Includes clinics, medical centres, physical restoration centres, laboratories, radiological facilities, and Red Cross blood depots.

TABLE 4 - NUMBER OF BEDS (EXCLUDING BASSINETS) IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, WITH RATIOS PER 1,000 POPULATION, CANADA AND PROVINCES, DECEMBER 31st, 1967

Province	Number of listed hospitals	Number of beds	Beds per 1,000 population
Newfoundland	47	3,008	6.0
Prince Edward Island	9	642	5.9
Nova Scotia	48	4,920	6.5
New Brunswick	41	4,118	6.6
Quebec	269	37,979	6.5
Ontario	316	48,649	6.8
Manitoba	103	6,963	7.2
Saskatchewan	159	7,975	8.3
Alberta	152	13,410	9.0
British Columbia	120	12,986	6.7
Yukon	5	159	10.6
Northwest Territories	29	432	14.9
Canada(a)	1,298	141,241	6.9

(a) The three listed hospitals in the U.S.A. are excluded.

TABLE 5 - TOTAL AND INSURED PATIENT-DAYS IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, WITH RATES PER 1,000 POPULATION, CANADA AND PROVINCES, 1967

Province	Number of hospitals reporting	Total patient-days		Patient-days paid for by the insurance plan of the reporting province	
		Number	Rate(a)	Number(b)	Rate(c)
Newfoundland	47	786,978	1,574	737,315	1,478
Prince Edward Island	9	187,335	1,719	180,276	1,685
Nova Scotia	48	1,387,294	1,833	1,255,081	1,698
New Brunswick	41	1,216,168	1,962	1,106,740	1,808
Quebec	267	11,027,663	1,879	10,378,718	1,774
Ontario	314	14,698,516	2,056	13,468,325	1,926
Manitoba	100	1,963,498	2,039	1,769,869	1,857
Saskatchewan	155	2,143,835	2,238	2,058,773	2,155
Alberta	152	3,604,609	2,419	3,363,969	2,271
British Columbia	118	3,847,701	1,976	3,337,460	1,726
Yukon	5	25,138	1,676	21,118	1,508
Northwest Territories	29	65,521	2,259	41,815	1,442
Canada	1,285	40,954,256	2,007	37,719,459	1,870

(a) Per 1,000 population based on intercensal estimates.
(b) Excludes out-of-province insured care.
(c) Per 1,000 persons insured under provincial plans.

TABLE 6 - AVERAGE LENGTH OF STAY (a) AND OCCUPANCY(b) FOR BUDGET REVIEW GENERAL, CHRONIC, AND CONVALESCENT HOSPITALS, CANADA AND PROVINCES, 1967

Province	General hospitals			Chronic hospitals			Convalescent and rehabilitation hospitals		
	Number of hospitals reporting	Average length of stay	Occupancy	Number of hospitals reporting	Average length of stay	Occupancy	Number of hospitals reporting	Average length of stay	Occupancy
	Number	Days	Per cent	Number	Days	Per cent	Number	Days	Per cent
Newfoundland	43	10.6	71.5	1	321.5	96.9	1	55.6	46.4
Prince Edward Island	8	10.2	80.8	-	-	-	1	34.6	60.5
Nova Scotia	44	10.9	76.0	-	-	-	2	33.0	94.6
New Brunswick	38	10.4	81.2	1	61.7	96.7	1	55.2	93.1
Quebec	132	10.4	77.6	29	162.4	94.9	4	44.1	83.9
Ontario	199	11.1	81.3	19	234.2	98.4	6	36.7	88.5
Manitoba	77	9.1	79.0	4	118.9	85.4	1	45.4	87.5
Saskatchewan	147	9.4	73.5	3	318.8	93.6	-	-	-
Alberta	113	8.9	71.3	25	179.5	89.6	1	81.1	96.3
British Columbia	89	9.1	82.0	6	247.4	93.2	5	61.4	83.5
Yukon	2	6.0	29.0	-	-	-	-	-	-
Northwest Territories	2	7.0	64.8	-	-	-	-	-	-
Canada	894	10.2	78.4	88	186.[illegible]	94.5	22	44.1	85.2

(a) Average hospital stay since admission of patients who left hospital by discharge, death, or transfer during 1967, excluding the newborn.

(b) Ratio of the average daily number of patients to the number of available beds.

The occupancy ratio during 1967 in general hospitals was 78.4 per cent; in chronic hospitals, 94.5 per cent; and in convalescent hospitals, 85.2 per cent. Occupancy varies with the size of hospital, and variations in the occupancy ratio among provinces can be partially attributed to this factor. Thus, Ontario and British Columbia, with many large hospitals, show the highest occupancy in general hospitals, and the territories, with no large hospitals, the lowest.

Table 7 shows that 3.2 million separations (discharges and deaths) were reported by listed hospitals in 1967. This represents a rate of 158 per thousand population. Provincial rates varied from 134 in Quebec to 215 in Saskatchewan; the rate for the Northwest Territories, 258 per thousand, was the highest.

Table 8 shows that listed hospitals reported 220,543 full-time hospitals employees, excluding trainees, at the end of 1967, which is 14,034 or 6.8 per cent more than the year before, while the number of part-time employees increased by 3,999 to 37,037.

Tables 9 and 10 deal with revenue fund expenditures of budget review hospitals only. These exclude capital costs, but include expenditures for services that are not covered by hospital insurance plans. The expenditures in 1967 increased by 16 per cent over the preceding year to $1,478 million, of which salaries accounted for two-thirds.

Expenditures per patient-day ranged from $29.43 in Prince Edward Island to $47.46 in Quebec, except for the Yukon where the cost per patient-day was $70.74. Regional differences reflect not only differences in the cost of labour and material, but also the proportion of care of geriatric and convalescent patients. This type of care is less costly than treatment of acute illness provided in budget review hospitals. The average cost per patient-day in Canada for care in budget review hospitals was $40.54 per patient-day in 1967, 12 per cent higher than in 1966.

The per capita amount of expenditures of budget review hospitals in 1967 ranged from $76.30 in Alberta to $50.59 in Prince Edward Island, and was far lower in the Territories. The national average was $72.45, exceeded only in Quebec ($75.75), Ontario ($75.99), and Alberta. Budget review hospitals provided 90 per cent of all insured patient-days in Canada in 1967, but interprovincial comparisons of the per capita cost of these hospitals may be misleading because that percentage varied considerably from province to province.

TABLE 7 - NUMBER OF SEPARATIONS (EXCLUDING NEWBORN) FROM HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS WITH RATES PER 1,000 POPULATION, CANADA AND PROVINCES, 1967

Province	Number of hospitals reporting	Separations	
		Number	Rate per 1,000 population
Newfoundland	47	69,764	140
Prince Edward Island	9	18,503	170
Nova Scotia	48	117,411	155
New Brunswick	41	106,872	172
Quebec	267	784,845	134
Ontario	314	1,085,082	152
Manitoba	100	173,600	180
Saskatchewan	155	206,360	215
Alberta	152	307,390	206
British Columbia	118	338,499	174
Yukon	5	2,881	192
Northwest Territories	29	7,490	258
Canada	1,285	3,218,697	158

TABLE 8 - EMPLOYEES IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS(a), CANADA AND PROVINCES, DECEMBER 31st, 1967

Province	Number of hospitals reporting	Number of employees	
		Full-time	Part-time
Newfoundland	47	5,072	321
Prince Edward Island	9	916	72
Nova Scotia	48	7,603	1,181
New Brunswick	41	6,753	641
Quebec	267	67,080	9,275
Ontario	314	77,794	15,567
Manitoba	100	10,198	2,627
Saskatchewan	155	9,980	1,711
Alberta	152	17,212	2,852
British Columbia	118	17,425	2,684
Yukon	5	149	7
Northwest Territories	29	361	99
Canada	1,285	220,543	37,037

(a) Excludes trainees; includes 119 full-time technicians employed by public-health laboratories and cancer clinics.

TABLE 9 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS, CANADA AND PROVINCES, 1967

Province	Number of hospitals reporting	Total expenditures	Expenditures per patient-day(a)	Expenditures per capita
		$'000's	$	$
Newfoundland	46	30,352	38.75	60.70
Prince Edward Island	9	5,514	29.43	50.59
Nova Scotia	47	51,521	41.15	68.06
New Brunswick	40	40,534	36.02	65.38
Quebec	177	444,523	47.46	75.75
Ontario	225	543,287	40.69	75.99
Manitoba	82	63,082	35.55	65.51
Saskatchewan	143	65,300	33.99	68.16
Alberta	142	113,686	33.93	76.30
British Columbia	102	119,783	35.88	61.52
Yukon	2	187	70.74	12.46
Northwest Territories	2	568	38.08	19.57
Canada	1,017	1,478,335(b)	40.54	72.45

(a) Excludes the newborn.
(b) Column does not add to total shown due to rounding of components.

TABLE 10 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS BY TYPE OF ACCOUNT, CANADA, 1967

Item	Total expenditures	Expenditures per patient-day(a)	Expenditures per capita(b)	Percentage distribution
	$'000's	$	$	
Salaries and wages	988,432	27.10	48.44	66.9
Medical and surgical supplies	45,110	1.24	2.21	3.1
Drugs	51,899	1.42	2.54	3.5
Raw Food	63,917	1.75	3.13	4.3
Other Expenses(c)	328,977	9.03	16.13	22.2
Total	1,478,335	40.54	72.45	100.0

(a) Excludes the newborn.

(b) Based on intercensal estimates.

(c) Includes electricity, maintenance, services, repairs, interest, depreciation, rent, and other supplies.

Table 10 shows that the largest cost component was salaries, 65.9 per cent of the total. This item has been increasing more rapidly than the other components, reflecting increased staff-patient ratios, increases in salaries generally, and the greater use of specially skilled personnel that modern hospital care requires.

Tables 11 and 12 are based on patients who left hospital in 1965. Table 11 shows how often people are in hospital (separations per 1,000 population), how much hospital care people use (days in hospital since admission per 1,000 population), and the average length of hospital stay, for different age-groups and by sex. Table 12 shows the same statistics as Table 11, by diagnostic category.

Subsection 5 - Dominion Council of Health

The Dominion Council of Health, established in 1919, advises the Minister of National Health and Welfare on matters relating to the promotion and preservation of the health of the people of Canada. It meets twice a year and consists of the Deputy Minister of National Health, who acts as chairman, and the chief health officer of each province, as well as up to five persons whom the Governor-in-Council appoints for a period of three years. Traditionally these are chosen from the field of agriculture, medical science, organized labour, and from women's organizations.

The Council is supported by special advisory committees who deal with specific aspects of public health and who are appointed by Order in Council.

Subsection 6 - Environmental Health

Environmental health. - Environment is the sum of all social, biological, physical or chemical factors which compose the surroundings of man. Deterioration and modification of the quality of our environment has resulted in an increasing need for the assessment of the health implications and for the development and stimulation of the use of methods to control or eliminate harmful environmental factors.

The problems of environmental health are increasing because of increasing environmental pollution, which is a product of the technological society in which we live. As technological advances continue, there is an ever increasing injection of

TABLE 11 - SEPARATIONS AND DAYS OF CARE SINCE ADMISSION: RATES PER 1,000 POPULATION; AND AVERAGE LENGTH OF STAY; FOR PATIENTS(a) INSURED BY PROVINCIAL PLANS, BY SEX AND AGE, CANADA, 1967

Item	0-4 years	5-14 years	15-24 years	25-44 years	45-59 years	60-64 years	65-74 years	75 years and over	All Ages
Separations per 1,000 population(b)									
Male	196	88	74	89	152	222	286	421	129
Female	153	78	224	237	172	193	238	341	185
Both sexes	175	83	149	163	162	207	261	377	157
Days in hospital since admission per 1,000 population(b)									
Male	1,576	524	610	900	2,154	3,792	5,806	11,379	1,611
Female	1,253	447	1,429	1,933	2,330	3,518	5,424	12,197	2,082
Both sexes	1,419	486	1,017	1,413	2,242	3,654	5,604	11,831	1,845
Average length of stay (days)									
Male	8.0	6.0	8.2	10.1	14.2	17.1	20.3	27.0	12.5
Female	8.2	5.7	6.4	8.2	13.6	18.2	22.8	35.7	11.3
Both sexes	8.1	5.8	6.8	8.7	13.8	17.6	21.5	31.4	11.8

(a) Excludes the newborn.

(b) Based on intercensal estimates.

Source: Provincial Plans

TABLE 12 - DIAGNOSES OF PATIENTS[a] INSURED BY PROVINCIAL PLANS[b], CANADA, 1967

Section of the International Classification of Diseases	Separations		Patient-days since admission		Average length of stay (days)	Percentage distribution	
	Number	Rate per 1,000 population	Number	Rate per 1,000 population		Separations	Patient-days
I. Infective and parasitic diseases	44,435	2.2	576,465	28.2	13.0	1.4	1.6
II. Neoplasms	187,698	9.2	3,465,858	169.8	18.5	5.9	9.3
III. Allergic, endocrine system, metabolic, and nutritional diseases	93,981	4.6	1,465,079	71.8	15.6	3.0	4.0
IV. Diseases of the blood and blood-forming organs	18,245	0.9	273,720	13.4	15.0	0.6	0.7
V. Mental, psychoneurotic, and personality disorders	96,811	4.7	1,702,774	83.4	17.6	3.1	4.6
VI. Diseases of the nervous system and sense organs	166,874	8.2	3,909,120	191.5	23.4	5.3	10.5
VII. Diseases of the circulatory system	271,294	13.3	5,583,990	273.6	20.6	8.6	15.1
VIII. Diseases of the respiratory system	488,616	23.9	3,200,625	156.8	6.6	15.4	8.6
IX. Diseases of the digestive system	438,835	21.5	4,464,746	218.8	10.2	13.8	12.0
X. Diseases of the genito-urinary system	278,780	13.7	2,512,915	123.1	9.0	8.8	6.8
XI. Deliveries and complications of pregnancy, childbirth, and the puerperium	498,351	24.4	2,885,798	141.4	5.8	15.7	7.8
XII. Diseases of the skin and cellular tissue	57,782	2.8	563,711	27.6	9.8	1.8	1.5
XIII. Diseases of the bones and organs of movement	116,119	5.7	2,082,464	102.0	17.9	3.7	5.6
XIV. Congenital malformations	33,100	1.6	476,528	23.4	14.4	1.0	1.3
XV. Certain diseases of early infancy	10,316	0.5	136,259	6.7	13.2	0.3	0.4
XVI. Symptoms, senility, and ill-defined conditions	85,047	4.2	613,457	30.1	7.2	2.7	1.7
XVII. Accidents, poisonings, and violence	283,361	13.9	3,173,628	155.5	11.2	8.9	8.6
All diagnoses	3,169,645	155.3	37,087,137	1,817.3	11.7	100.0	100.0

(a) Excludes the newborn and certain special cases, such as examinations, inoculations, fittings, etc. (Y00-Y18, Y40-Y88 of the International Classification of Diseases).

(b) Some provinces included cases that were not paid for under their plans. Others excluded insured cases where the patients were treated outside the province. Saskatchewan excluded data from four geriatric hospitals.

man-made products into the air, water and soil environment, usually as waste or by-products and often at low concentrations.

Many pollutants are known to affect health. The relationship between deleterious pollutants and their effects on health depends on a number of factors including their concentration and the duration of exposure. Of particular importance are such factors as the possibility of some or total recovery between periods of exposure, the variability in susceptibility to disease from individual to individual, and effects associated with simultaneous or superimposed exposure to two or more pollutants. Much remains to be done but the considerable evidence of potential long-term serious consequences of environmental pollution on health justifies the increasing concern and need for increased activity.

Programs to protect workers in their occupational environments have been carried on by occupational health officials for a number of years. It is only in recent years, however, that health officials have been directing their attention to health hazards in the general environment. For example, although there is a long history of activities concerned with the health effects of noise in the industrial and agricultural environment, attention is also now being focussed on the health effects of community noise.

The various agencies in Canada with a concern about environmental health develop and implement programs to assess and develop preventive and control measures directed to air and water pollution, radiation, industrial toxicants, and other factors of the general, occupational, and home environments known to be, or suspected of being, deleterious to human health.

The complexity of environmental health studies requires specialists from a variety of disciplines falling within the broad spectrum of physical, life and engineering sciences. Individual tasks range from field surveys and interpretation of air and water pollution, research into health effects and their causes from all kinds of toxicants, and development of guides and standards for pollutants such as chemicals and other hazards in both the working and general environment, to specifying health and safety standards for radiation-emitting devices. These concerns have become major problems requiring the co-operative efforts of governments and other agencies that are concerned about environmental quality.

The federal government discharges its responsibilities in environmental health through the Environmental Health Directorate of the Department of National Health and Welfare. The Directorate is currently composed of four Divisions - Occupational Health,

Public Health Engineering, Radiation Protection and Air Pollution Control. The latter division was created in late 1969.

The ten provinces of Canada have agencies to deal with the problems of water supply, sewerage systems and water pollution. Six provinces have agencies to handle air pollution problems and agencies to deal with occupational health and one province is in the process of establishing an occupational health unit.

Co-ordination of the many activities within provinces and between the provinces and the federal government is usually provided by advisory boards or committees.

Section 3 - Provincial and Local Health Services

Provincial governments are primarily responsible for the various health measures to prevent disease and improve the health standards of the community. These comprise preventive health services, hospital services, mental health services, treatment services for tuberculosis and other diseases, and special treatment services and care of the chronically ill and disabled. They are usually administered by the provincial health department or other official agency in co-operation with the hospitals and voluntary health organizations, the health professions and the teaching and research institutions.

Although the pattern of services is similar, provincial health organization, financing, and administration vary to some degree. Most health functions are exercised by the provincial health departments, but in some provinces, certain programs such as hospital insurance, medical care insurance, tuberculosis control, cancer control, or alcoholism programs are administered by separate public agencies directly accountable to the minister of health. Voluntary organizations also provide specialized health services, often with some support from tax funds in the form of payment for services or support grants.

In general, the provincial health departments carry out overall planning and direction of public health programs, administer certain specialized health programs, and assist through technical and financial aid the regional or local health units and city health departments that have been delegated responsibility for the basic public health services. In most provinces, the health unit systems, which serve mainly rural areas, are operated either by the province or jointly by the province and the local authority, with the local authority having jurisdiction over county, municipality or

region, while city health departments are administered by municipal or metropolitan boards of health. Several provincial health departments also directly administer health services to northern unorganized territories. The nucleus staff of a local health unit or department usually is composed of a full-time medical officer of health, a number of public health nurses and a public health inspector.

Local programs to safeguard community health are concerned with environmental sanitation to ensure safe water, milk, and other foods, prevention and control of infectious diseases through use of vaccines and prophylactics, improvement of maternal and child health and dental health, registration of vital statistics, and health education and counselling. In addition, the larger city health departments have developed specialized services in such areas as mental health, home care, and rehabilitation of the chronically ill and the handicapped. A few health units and departments in most provinces have started health screening for chronic conditions and family planning clinics. The city health departments participate with the provincial authorities in accident prevention and in measures to control air, water, and soil pollution.

Provincial health departments support the local programs by grants-in-aid and the provision of technical consultant services. Most of the mental and tuberculosis hospitals and clinics are provincially operated, as are treatment services for the veneral diseases, cancer, alcoholism, and other specific diseases, and the laboratories that aid both the public health agencies and practising physicians in diagnostic and control procedures. The provincial agencies are primarily responsible for the collection and analysis of vital statistics and the study of the epidemiological and related social and economic conditions that affect health. They also give leadership in such fields as occupational health, nutrition, health education, and pollution problems, in collaboration with national health agencies. In order to maintain and improve the health services, the provincial health departments recruit and train professional and technical personnel for the health fields and support public health research.

Subsection 1 - Public Health Services

Occupational health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industrial management. Provincial agencies regulate working conditions and offer consultant and educational services

to industry. All provinces have legislation (factory acts, shop acts, mines acts, workmen's compensation acts) setting standards for health safety and accident prevention on the job. Most provinces maintain environmental health laboratories that study industrial health problems such as the effects of noise and air conditions on workers.

Communicable disease control. - The larger provincial health departments have separate divisions of communicable disease control headed by full-time epidemiologists whereas in the smaller provinces this function is combined with one or more community health services. Local health authorities organize public clinics for immunization against diphtheria, tetanus, poliomyelitis, whooping cough, smallpox, and measles. They also engage in case-finding and diagnostic services in co-operation with public health laboratories and private physicians. Special services for tuberculosis and venereal disease are noted on pages 39 and 41.

Health education. - A basic concern of provincial health authorities is to stimulate public interest in important health needs, and most provincial health departments have a division or unit of health education under a full-time professional "health educator" to promote public knowledge of health needs and measures. The division provides education materials to other divisions of the health department, to local health authorities, to voluntary associations, and to individuals. Many educational activities are directed to accident prevention and to reducing habits harmful to health, such as cigarette smoking and the excessive use of alcohol and other drugs. All health workers carry out health education as part of their normal activities.

Public health laboratories. - All provinces maintain a central public health laboratory and most have branch laboratories to assist local health agencies and the medical profession in the protection of community health and the control of infectious diseases. Public health bacteriology (testing of milk, water, and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical testing for physicians and hospitals steadily increasing in volume.

Maternal and child health. - Public health nurses employed by the local health services carry out preventive health services to mothers, newborns, and children through clinics, home and hospital visits, and school health services. All provincial health departments have established maternal and child health consultant services that co-operate with the

public health nursing services. The maternal and child health divisions established in five provinces also undertake studies in maternal and child care, including hospital care, and assist in the training of nursing personnel.

Nutrition. - Provincial health departments and some city health departments employ consultants in nutrition to extend technical guidance and education to health and welfare agencies, nursing homes and other care institutions and hospitals. They also provide diet counselling to selected patient groups and conduct nutritional surveys and other research.

Dental health. - Provincial dental public health programs have been largely preventive, but increasing emphasis is now being given to dental care. Dental clinics conducted by local health services are generally restricted to pre-school and younger school age groups. A number of provinces send dental teams to remote areas and subsidize resident dentists to practise in areas lacking such services, while the four western provinces have dental care schemes of varying coverage for welfare recipients. Other activities of the public dental health programs are directed to the training of dentists and dental hygienists, the conduct of dental surveys, and the extension of water fluoridation.

Subsection 2 - Mental Health Services

Mental health services in Canada are organized as part of provincial health services. Each province employs a director of mental health services, usually a psychiatrist, and one or more consultants in psychiatric nursing, clinical psychology, social work, occupational therapy or special education and also one or more psychiatrists specializing in paediatrics, geriatrics, mental retardation, alcoholism and drug addiction, or other related fields. As public health officers, the mental-health directors are responsible for the development of programs aimed at prevention of mental disease and for the general promotion of mental health, on their own and in co-operation with welfare, education, manpower, labour, and justice departments. As psychiatrists they are responsible for development and supervision of the various health facilities for the treatment of people who suffer from mental or emotional disorders including disorders of character and behaviour, the mentally retarded, people with damage to the nervous system, alcoholics, and drug addicts.

Mental health services differ in detail and stage of development from province to province; all are being extended and improved to take advantage of the best methods of treatment and prevention. The traditional pattern of long-term care of the mentally ill and retarded in large isolated mental hospitals and in hospitals for mentally defectives is giving way to new patterns of care that are designed to cure the afflicted or, failing that, to provide for them living and working environments that will enable them to lead reasonably normal lives.

The mental hospitals now place less emphasis on custodial care and more on intensive psychiatric treatment. They admit voluntary patients who receive much the same care and treatment as they would receive as patients in a general hospital. Many of those who would not profit from intensive psychiatric treatment -- the severely retarded and people with severe mental deterioration -- are supported under welfare auspices in sheltered workshops, nursing homes, or foster homes, and continue to receive medical care. In addition to the mental hospitals some special "psychiatric" hospitals provide intensive psychiatric care over short periods, and psychiatric units and out-patient psychiatric departments are being established in large general hospitals. Local authorities or provincial health departments operate mental-health clinics in most large cities and travelling clinics visit suburban and rural areas. Psychiatric hospitals and mental-health clinics are establishing more day-care and night-care facilities through which some patients receive part-time hospital care and therapy during the day and go home at night and others go to work during the day and return to hospital in the evening for treatment.

Extending mental-health services into the community aims at preventing severe mental and emotional breakdowns and at reducing the number of people requiring treatment in institutions. Under the terms of the federal-provincial medical care legislation, in effect in seven provinces as of March 31, 1970, the services of private psychiatrists should become more widely available. Through early diagnosis and treatment in a mental-health clinic or out-patient department of the hospital in the patient's neighbourhood, he may continue to live at home and pursue his normal occupation while receiving treatment.

Special centres are being established for the study and treatment of alcoholism and drug addiction, criminal psychopathy, psychiatric disorders in children, brain injuries, and other neurological disorders. Studies recently instigated by the federal government in these and related areas have included a survey of residential and in-patient services for emotionally

disturbed children and the appointment of the Commission of Inquiry into the Non-Medical Use of Drugs. The interim report of its findings and recommendations was tabled in the House of Commons on June 19, 1970; its principal recommendations are mentioned in the Introduction to this volume. In addition, the provinces are amending the pertinent legislation in order to guarantee the rights of the mentally ill, the emotionally disturbed, and the intellectually retarded.

The continuing efforts by provincial health departments to provide more and better mental-health services reflect growing enlightenment about mental health on the part of the medical profession, the general public, and government agencies. Improvement in the care of psychiatric patients has been fostered by activities of voluntary organizations such as the Canadian Mental Health Association and the Canadian Association for the Mentally Retarded; by the professional advice of the Canadian Medical Association and the Canadian Psychiatric Association; by the national health grants and the national welfare grants for new services, professional training, and scientific research; and through the information programs of the Mental Health Division of the Department of National Health and Welfare.

In the field of mental retardation, the federal government instituted a Mental Retardation Grant in 1967-68 over a five-year period to support health and welfare demonstration and research projects conducted by voluntary agencies for the mentally retarded. The amount allocated to this grant was $500,000 annually for the period 1967-68 to 1969-70, and $400,000 in 1970-71.

Subsection 3 - Services for Specific Diseases or Disabilities

Tuberculosis and respiratory diseases. - New active cases of tuberculosis in Canada in 1968 amounted to 4,824 or 23 per 100,000, and in 1969 the total was 4,438 or 21 per 100,000. Reactivated cases reached 755 in 1968 and 680 in 1969. Deaths again decreased, to 630 in 1968. It is estimated that more than half of the Canadian population aged 55 years and over are positive reactors who harbor the tubercle bacillus; most active cases arise from reactivations of the disease among this group. North American Indians, Métis, and Eskimos experience much higher morbidity and mortality rates for tuberculosis and other respiratory diseases than do the rest of the Canadian population.

Provincial health departments, assisted by voluntary agencies, conduct anti-tuberculosis case-finding programs through community tuberculin-testing and X-ray surveys, with special attention to high-risk groups, routine hospital admission X-rays, and follow-up of arrested cases. However, practising physicians detect the greatest number of new cases.

B.C.G. vaccine, estimated to be effective for 80 per cent of those vaccinated, is used in most provinces to protect high risk groups. Quebec and Newfoundland routinely immunize children and in the Yukon B.C.G. is routinely administered to all newborn. Treatment, including hospital care, drugs and rehabilitation services, is free in all provinces. Chemotherapy has shortened hospital stay and facilitated out-patient or domiciliary care.

An annual federal grant of $20,000 is made to the Canadian Tuberculosis and Respiratory Diseases Association to improve the quality and efficiency of health services. Because tuberculosis and other respiratory diseases still present serious health problems, research into the characteristics of afflicted persons, as well as research into the nature and treatment of respiratory diseases, is supported under the Public Health Research Grant (estimated at $202,600 in 1970-71), while related research is also carried out within the Department of National Health and Welfare. Other agencies known to be supporting research in this field in 1969-70 are the Canadian Tuberculosis and Respiratory Diseases Association ($123,050 plus funds for two fellowships), the Ontario Thoracic Society ($97,650), the Muskoka Hospital Memorial Research Fund ($61,273), and the British Columbia Tuberculosis Christmas Seal Society ($30,814 plus one fellowship).

The National Tuberculosis Reference Centre in Ottawa was opened in 1968 to establish uniform standards in testing for resistance to anti-tuberculosis drugs.

Cancer. - Cancer in 1968 accounted for 18.7 per cent of all deaths in Canada, and the standardized cancer death rate increased to 137.9 (152.0 for males and 123.8 for females). It is estimated that in Ontario, for example, one in every three residents may expect to develop some form of cancer. In Canada, cancer ranks second highest as a cause of death; and over 91 per cent of the deaths from cancer occur after 45 years of age. Special provincial agencies for cancer control, usually in the health department or a separate cancer institute, carry out cancer detection and treatment, public education, professional training, and research in co-operation with local public health services, physicians, and the voluntary Canadian

Cancer Society branches. Although the provisions are not uniform, all cancer programs provide a range of free diagnostic and treatment services, to both out-patients and in-patients, that is financed by the hospital insurance programs or the federal-provincial cancer control grants. Hospital insurance benefits for cancer patients include diagnostic radiology, laboratory tests, and radiotherapy. The cancer control programs in Saskatchewan and New Brunswick also pay for medical and surgical services; in most provinces these costs are covered under the public medical care insurance schemes.

Venereal diseases. - Because of under-reporting, public health authorities consider the prevalence of venereal disease to be much higher than the number of cases recorded.(1) In 1969 there were 2,327 cases of syphilis and 27,111 cases of gonorrhea reported in Canada. In 1968, venereal diseases continued to head the list of reported notifiable diseases, with a combined rate of 119.3 cases per 100,000 population; the rate for syphilis was 10.8 cases per 100,000, and for gonorrhea, 108.6 cases per 100,000. In 1969, the combined rate rose to 140.4 cases per 100,000; the syphilis rate recorded was 11.4 cases per 100,000, and the rate for gonorrhea was 129.0 cases per 100,000. Fifteen per cent of all new cases of infectious venereal disease were reported among persons aged 15-19 years.

The real impediments to control of venereal disease are attitudes and behaviour patterns that permit cases to go untreated and contacts unlocated. Provincial health departments operate clinics which provide free diagnostic and treatment services, and in some areas the departments pay private physicians to provide free treatment to indigents. In addition, the provinces supply free drugs to physicians for treating private cases. Local departments of health carry out case-finding, follow-up of contacts and maintain health education programs.

Alcoholism. - In all provinces, health departments or other official agencies administer programs for the prevention and control of alcoholism, including public education and related studies. Conservative estimates place the number of Canadians currently requiring these services at 270,000, if a

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(1) Recent surveys in the United States indicate that the number of persons treated for infectious venereal disease is actually three to four times higher than the number reported; a similar degree of under-reporting is believed to exist in Canada.

clinical definition of alcoholism is used. Treatment services available are mainly for out-patients, but with the increasing awareness of the need for in-patient services, most provinces have expanded facilities offering in-patient services. Other facilities operated by official and voluntary agencies include hostels and special farms or prison centres for chronic offenders with drinking problems. In several provinces, detoxication wards have been set up to treat alcoholics in preference to use of jails. Several provincial alcoholism agencies (Ontario, Quebec, and Saskatchewan) have broadened their programs to include other addictions, and British Columbia supports a separate narcotic addiction foundation. Because addictions are widely prevalent, hospitals, mental health services, and other public and voluntary health and social agencies are also involved in their diagnosis and treatment.

Other diseases or disabilities. - Many services for persons with chronic disabilities, such as heart disease, arthritis, diabetes, visual and auditory impairments, and paraplegia have been initiated by voluntary agencies assisted by federal and provincial funds. Today, treatment for specific conditions is available at hospital out-patient clinics and in-patient or day centres, at separate clinics and rehabilitation centres and under home care programs (see page 58).

Subsection 4 - Public Medical Care Programs

Prior to the establishment of government-administered medical insurance in most provinces over the last few years, prepayment arrangements to cover the cost of physicians' services, mainly voluntary as regards enrolment, had developed rapidly in both the public and the private sectors.

By the end of 1968 basic medical or surgical coverage, or both, was being provided to about 17,167,000 Canadians, representing 82.0 per cent of the total population (figures are set out in Table 13). Of these, the voluntary plans operating purely in the private sector provided coverage for 10,906,000 persons or 52.1 per cent, and public plans of various kinds covered 6,261,000 persons or 29.9 per cent.

At the end of 1969, with public medical care programs implemented in seven provinces, insurance for physicians' services covered 18,885,000 or 88.8 per cent of the population. Public plans then accounted for coverage of 70.8 per cent of the total population, or 15,058,000 persons; their coverage had gone up by 8,797,000 persons over the previous year. Private

TABLE 13 - ESTIMATED NUMBER OF PERSONS COVERED FOR PHYSICIANS' SERVICES BY MEDICAL CARE INSURANCE AND OTHER PLANS, CANADA, DECEMBER 31, 1968 AND 1969

Type of Agency	1968	1969
	(000)	(000)
Total population of Canada	20,940	21,260
Private agencies		
Insurance company plans	5,303	1,960(a)
Non-profit voluntary plans	5,013	1,660(a)
Independent plans	590	207(a)
Total, private agencies	10,906	3,827
Per cent of population covered by private agencies	52.1	18.0
Public agencies		
Provincial government insurance plans		
Alberta Health Plan(b)	289	1,564
Ontario Medical Services Insurance Plan(c)	1,592	7,154
British Columbia Medical Services Plan	1,857	2,046
Saskatchewan Medical Care Insurance Plan (including Swift Current Health Region)	936	949
Newfoundland Medical Services(d)	343	514
Nova Scotia	--	746
Manitoba	--	971
Provincial government medical services		
Social Assistance Plans(e)	758	623
Mental hospitals	68	69
Tuberculosis sanatoria	4	4
Federal government medical services		
Indian and Eskimo medical services(f)	232	234
Canadian Armed Forces	98	98
Royal Canadian Mounted Police	9	10
Department of Veterans Affairs(f)	52	53
Penal institutions	23	23
Total, all public agencies	6,261	15,058
Per cent of population covered by all public agencies	29.9	70.8
All medical agencies, private and public	17,167	18,885
Per cent of population covered by all medical agencies	82.0	88.8

SOURCES: Unpublished data from Department of National Health and Welfare; Survey of Voluntary Insurance in Canada, Canadian Conference on Health Care (Toronto), December 5, 1969.

(a) Includes plans operating only in Prince Edward Island, New Brunswick and Quebec.
(b) Became The Alberta Health Care Insurance Plan, July 1, 1969.
(c) Became The Ontario Health Services Insurance Plan, October 1, 1969.
(d) Became The Newfoundland Medical Care Plan, April 1, 1969.
(e) These are residual figures comprising all recipients under the Canada Assistance Plan not already covered for physicians' services under overall medical insurance plans. The total number of recipients under the Canada Assistance Plan was estimated at 1,283,000 in 1968 and 1,336,000 in 1969. Overall medical insurance plans in 1968 covered 83,000 of them in Newfoundland, 273,000 in Ontario, 55,000 in Saskatchewan and 114,000 in British Columbia for a total of 525,000. Physicians' services for the 758,000 in the other provinces were provided under separate plans. By 1969, overall medical insurance covered 87,000 for physicians' services in Newfoundland, 45,000 in Nova Scotia, 284,000 in Ontario, 46,000 in Manitoba, 57,000 in Saskatchewan, 75,000 in Alberta, and 119,000 in British Columbia, for a total of 713,000. Physicians' services for the 623,000 in the remaining provinces not yet embarked upon overall medical insurance plans were continued under separate programs and included 11,000 in Prince Edward Island, 48,000 in New Brunswick, and 564,000 in Quebec.
(f) In large degree, coverage of Indians and War Veterans' Allowance recipients for physicians' services was being integrated into medicare plans in 1969, and in some instances may be included in the coverage shown for medical care insurance plans.

plans, by contrast, represented 18.0 per cent of total coverage. It was anticipated that by the end of 1970, all ten provinces would have implemented public plans.

The federal grants-in-aid programs for provincially-administered medical care insurance plans became effective July 1, 1968, as noted in an earlier subsection.

The four criteria for acceptability set out in the federal legislation leave each province with substantial flexibility in determining the administrative arrangements for the operation of its medical care insurance plan and in choosing the way in which its plan will be financed, e.g., through premiums, sales tax, other provincial revenues or by a combination of methods.

In addition to the comprehensive physicians' services which must be provided as insured benefits by participating provinces, most plans also make provision for other health-care benefits that are part of the basic contract but towards the cost of which the federal government does not contribute. Refraction services by optometrists are included in all provincial plans except those of Nova Scotia and Newfoundland. A restricted volume of services provided by such practitioners as chiropractors, podiatrists, osteopaths, and naturopaths may also be insured. Residents may, if they wish, continue to seek insurance protection, generally from private voluntary agencies, for such additional services as dental care, special duty nursing, and prescribed drugs.

Two of the seven provincial medicare plans, Newfoundland and Nova Scotia, finance their portions of total costs from general revenues only and there is thus virtually no direct cost to families apart from extra-billing that doctors may in some instances impose. Five plans employ premiums to help finance their shares of costs. Typically, premiums are paid for welfare recipients, and various devices are used to keep the financial burden low for families that are poor but just above the poverty line entitling them to welfare assistance. The premium itself is kept low in Saskatchewan and Manitoba, although in Saskatchewan the effect of the lowness of the premium may be offset somewhat by the "utilization fee", i.e., direct payments to the doctor of $1.50 to $2.00 that are imposed for certain services as they are rendered (these fees can range from as low as 5 to 10 per cent to as high as 50 per cent of the approved charge). The problem of minimizing the burden is approached differently in Ontario, Alberta and British Columbia: premium levies are relatively high in their programs, but subsidies are available to reduce

the cost of premiums to families and individuals with little or no taxable income in the preceding year.

Modes of paying doctors can also have an effect upon how much of the total cost of physicians' services continues to be borne directly by patients. In Saskatchewan, Manitoba, and Newfoundland, an undertaking by the doctor to submit his bill directly to the insuring authority for payment carries with it a requirement, usually, that the amount paid (i.e., typically 85 or 90 per cent of the fee for the service, as specified in the fee schedule of the provincial medical association) represents payment in full for the service. In the other four provinces the mode of direct-billing-to-public-authority does not preclude extra billing provided the doctor indicates his intention to the patient beforehand. In Nova Scotia and British Columbia the extra-billing physician is also required to obtain prior written agreement from the patient, and to notify the public authority of the extra charge.

In all participating provinces a doctor electing, alternatively, to submit his bill to the patient, rather than to the public authority, for payment may legally charge the patient any amount. The patient will be reimbursed by the insuring authority only on the basis of what the authority defines as the approved fee. Even under these circumstances the physician is required in most provinces to advise the patient, before rendering a service, that he intends to charge in excess of the amount of the reimbursement that the patient can expect from the authority. In two provinces, British Columbia and Nova Scotia, the requirement to obtain prior written agreement from the patient with respect to extra charges also applies to non-participating physicians. Notwithstanding these various arrangements it is believed that doctors typically waive the right to collect extra amounts from low income patients.

Not all aspects of private insurance for physicians' services were phased out after 1968. In Saskatchewan two non-profit private plans continued as fiscal intermediaries to transmit claims and payments between physicians and the public insurance administration. In Ontario, British Columbia and Nova Scotia, certain private insurance agencies continued as non-profit carriers performing administrative functions such as enrolment, checking eligibility, and paying claims, on behalf of or under the supervision of the public insurance authority. In other provinces the tendency was to absorb the administrative apparatus of the private agency into the public authority.

Whether integrated or not into the public insurance authority as regards physicians' services insurance, several private plans have continued to offer policies to protect against the costs of prescribed drugs, private-duty nursing care, services of paramedical personnel, and other services not yet covered by the government plans.

Each of the seven plans in operation is described briefly in the paragraphs that follow, in chronological order of entry into the national program. For Saskatchewan, sufficient data on operations are available to indicate how the program is being utilized. It must be noted that although most doctors are paid on a fee-for-service basis, alternative or additional arrangements include salary, sessional payments, contract service, capitation, and incentive pay.

The program description and statistics below relate to operations, in most provinces, of the principal agency making payments for physicians' services. Such agencies do not represent the total public involvement in physicians' services, since payments may also be made by workmen's compensation boards, by hospital insurance administrations, or, for certain groups excluded from the coverage provided by the provincial jurisdiction, by the federal or other agencies responsible.

Saskatchewan - This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory and amount to $24 per year for a family and $12 per year for a single person. These premiums cover only a small portion of the costs of the program. Welfare recipients are automatically covered and no premium payment is required for them.

Program description and data given below for Saskatchewan, for 1969, are confined to the operations of the Medical Care Insurance Commission, which is the principal administering agency for the overall provincial public authority concerned with prepaid medical care. The Commission makes payments to doctors for the bulk of the services provided under the Plan. A segment of the population obtains its insured services under terms and conditions identical to those by the Commission, by way of the separate administering agency known as the Swift Current Health Region. Also, the provincial authority arranges for payment for care in mental and tuberculosis institutions and for cancer control.

In the program of the Medical Care Insurance Commission, medical benefits include home, office and hospital visits, surgery, obstetrics, psychiatric care outside mental hospitals,

anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions. Refractions by optometrists are also an insured benefit.

The Medical Care Insurance Commission pays for approved services on the basis of 85 per cent of the fees listed in the physicians' fee schedule*, except for certain classes of services where a utilization charge applies. These utilization charges are $1.50 for each office visit and $2.00 for each home and out-patient call and are payable by the patient to the attending physician. In such instances the financial responsibility of the public authority is reduced by the amount of the applicable fee. To avoid financial hardship to patients in exceptional cases there is provision for a family maximum on the total amount of such fees that must be paid. Welfare recipients are not required to pay utilization fees: instead, the medical profession by agreement accepts 85 per cent as payment in full for all services rendered to welfare patients. The co-charges are thus paid by the provincial government (or by the federal government on behalf of such additional exempted groups as Indians and recipients of war veterans allowances).

Physicians may elect to receive payment in three ways. First, the physician may receive directly from the public authority payment of 85 per cent of the tariff in the current fee-schedule of the medical association less the utilization fee, and accept this payment, along with the utilization fee payable by the patient, as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also the physician receives 85 per cent of the tariff less the utilization fee. Thirdly, a physician may elect to submit his bill directly to the patient who pays him either before or after seeking reimbursement from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. No physician is compelled to confine himself to one or the other of these modes of payment. Physicians in 1969 submitted 46.0 per cent of the total 2,989,000 claims received; approved agencies 44.5 per cent; patients 6.5 per cent; and optometrists 3.0 per cent.

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*Effective August 1, 1970, the basis of payment was changed to 100 per cent of the 1968 fee schedule for most visits, and upward revisions were made in payments relating to X-ray interpretations and fees in anaesthesia.

During 1969 a total of 627,094 persons out of 910,680 eligible residents received services costing $27,388,600. This aggregate dollar figure was 17.1 per cent higher than two years previously, in 1967.

The changes in total costs can be attributed to a number of factors, some being simply changes in population coverage and broader benefits, and others the impact of fee increases and utilization charges*.

Overall population increase was of itself an almost negligible factor in the higher costs. But the addition of War Veterans Allowance and certain Indians as beneficiaries accounted for an additional $1,300,000 in payments in 1969 over 1967. Refractions by physicians and optometrists became new benefits during the period and these accounted for about $1,175,000 of the higher costs in 1969.

A new payment schedule accounted for an expenditure of $5,100,000 in 1969 over what costs would have been had there been no change in fee schedules.

Against this increase must be placed the offsetting effect of new utilization charges which reduced total costs by an estimated $3,000,000 below what they otherwise might have been in the absence of such charges.

In previous years similar adjustments to measure the effect of various factors had shown that, in the absence of such new influences as higher fee levies which increase costs, and utilization charges which reduce costs, the per capita rise in payments attributable to other factors had been modest, of the order of 2.5 to 5.8 per cent per year from 1964 to 1967.

Of the total of beneficiaries in the province, 84.4 per cent had insurance protection through direct payment of premiums by heads of households. An agency of the provincial government paid the premiums on behalf of another 6.1 per cent, who were welfare recipients. The federal government paid the premiums for recipients of War Veterans Allowances and for Indians, who comprised 0.2 and 3.3 per cent respectively of the population. Another 5.5 per cent of the population were resident in the Swift Current Health Region and protected for a similar range of benefits, and 0.2 per cent who were patients in mental and tuberculosis institutions also had assured coverage for physicians' services. Finally, the federal government assumed

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*Annual Report, 1969, The Saskatchewan Medical Care Insurance Commission, Table 3.

complete responsibility for protection of that 0.3 per cent of the population -- comprising members of the Canadian Armed Forces and the Royal Canadian Mounted Police, and inmates of federal penitentiaries -- not eligible for coverage under medicare.

During 1969, as previously mentioned, a total of 627,094 persons received services costing $27,388,600. Close to one-third, or 31.1 per cent, of the 910,680 beneficiaries of the Medical Care Insurance Commission received no approved medical services during the year. For the largest proportion, 54.0 per cent, payments did not exceed $50. Payments for 7.2 per cent of the population ranged from $50 to $100; for 5.0 per cent, from $100 to $200; for 2.4 per cent, from $200 to $500; and for 0.2 per cent, from $500 to $1,000. Only 182 beneficiaries out of the total of 910,680 required payments exceeding $1,000.

Payments per person, at $41.99, were highest for members of 2-person families, contrasted with an average of $30.07 per person for all family sizes taken together. Payments were also relatively high for single-person households, at $36.85. Payments per person tended to range downward as family size increased, reaching $20.86 for 6 to 9 person families and increasing slightly to $21.81 for families of more than 9 persons. It is clear, of course, that aggregate payments, taking all members of the family together, tend to be highest in large-size families.

Most frequent use of items of services was by the very young and the very old. In age-group-specific terms, every beneficiary one year of age or under received 12.5 services during the year, every beneficiary 65 to 69 years of age, 10.0 services, and every beneficiary age 70 years and over, 14.8 services. The lowest demand for care was among beneficiaries 5 to 14 years of age, at 2.7 services per beneficiary. The rate rose progressively with advancing years, at 4.1 per beneficiary for the 15 to 24 years' age group, 5.3 for those 25 to 44, and 6.9 for those 45 to 64.

Of all services provided, the most frequent were office, home, and hospital visits, comprising 3,437 or 61.4 per cent of the total of 5,596 services per 1,000 beneficiaries. Laboratory services totalled 1,136 or 20.3 per cent and diagnostic radiology and other diagnostic procedures, 261 or 4.7 per cent. Surgery, obstetrics, anaesthesia, and surgical assistance accounted for 279 services or 5.0 per cent, and allergy services and therapeutic procedures, for 187 services or 3.3 per cent. Consultations made up 1.5 per cent of the total of 5,596 services, psychiatric services, 1.2 per cent,

refractions by physicians, 0.9 per cent, and refractions by optometrists, 1.7 per cent.

In terms of dollar payments per 1,000 beneficiaries, of a total of $30,075, the visits and examinations component accounted for $12,148 or 40.4 per cent, laboratory services for $1,314 or 4.4 per cent, and radiology and other diagnostic procedures for $2,279 or 8.1 per cent. Surgery, obstetrics, anaesthesia and surgical assistance totalled $9,633 or 32.0 per cent. Allergy services and therapeutic procedures comprised 2.6 per cent, consultations 5.8 per cent, psychiatric services 2.3 per cent, refractions by physicians 1.7 per cent, and refractions by optometrists 2.8 per cent.

General practitioners supplied, as in 1967 and 1968, about 85 per cent of home, office, and hospital visits. Doctors in specialist practice accounted for the remainder. The general practitioners' share of payments for these services was 82.3 per cent in 1969.

Payments by the Commission went mainly to 420 active general practitioners and 272 active specialists, the term "active" being defined as comprising physicians receiving $10,000 or more from the commission during the year (others providing insured service would be doctors either part time in practice or in the province only part of the year). The number of registered doctors in the province was 958, excluding the Swift Current Health Region, but including retired physicians and those engaged in teaching, research, administration, and public health and industrial medicine.

British Columbia - The province became a participant under the federal Medical Care Act on July 1, 1968. The plan is governed by a public commission with jurisdiction over a number of "licensed carriers", which are non-profit agencies charged with responsibility for day-to-day management of the separate components of the program. In addition to physicians' services and a limited range of oral surgery in hospital, the benefits include refractions by optometrists, some orthoptic services, limited physiotherapy, special nursing, chiropractic, and naturopathy.

Participation in the program is voluntary. At the end of 1969 2,046,000 persons or 96.7 per cent of the population was covered.

Premiums are $5.00 per month for single persons, $10.00 per month for 2-person families, and $12.50 per month for families of 3 or more. For eligible residents, the government

offers subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. Welfare recipients are automatically covered without payment of premium.

Payment is made at 90 per cent of the current fee schedule. Physicians either bill patients for services rendered, or accept payments directly from a licensed carrier. In the former case the physician has to notify the patient in writing, before rendering a service, that he is a non-participating physician, and the patient has to agree in writing that he is prepared to pay more than the amount of reimbursement that he may receive from the public authority. In the latter case, the physician may also charge a fee in excess of the tariff provided the patient has been duly notified, he agrees in writing to the extra charge, and the amount of the extra charge is made known to the Commission.

In British Columbia, by agreement between the Plan and the medical profession, fees are adjusted periodically on the basis of a formula that takes into account changes in price and wage levels in the consumer and industrial sectors.

Newfoundland - This province, together with Nova Scotia and Manitoba, became a participant on April 1, 1969. The Plan covers all medically-required services by doctors, plus a limited range of oral surgery in hospital. Refractions by optometrists are not a benefit.

All eligible residents are covered and there are no premium levies, the provincial portion of total costs for insured services being met from general revenues.

In Newfoundland benefit payments are limited to 90 per cent of the fee schedule. Physicians must formally select, and use exclusively, one of the modes of payment available. A participating physician must accept 90 per cent of the fee schedule as payment in full. A non-participating physician may impose additional charges provided he informs the beneficiary that he is not a participating physician and that he reserves the right to charge in excess of the amount payable by the Plan.

Traditionally, large numbers of doctors in Newfoundland have contracted with the provincial government and with certain voluntary agencies to receive salaries for service in outlying areas. These arrangements were continued after April 1, 1969.

Nova Scotia - Nova Scotia became a participating province on April 1, 1969. All eligible residents are covered. Registration is required but there are no premiums, the entire amount of the provincial portion of the costs of insured services being obtained from general revenues.

The insured services include all medically necessary procedures by practitioners, plus a limited range of oral surgery procedures in hospitals. Refractions by optometrists are not a benefit.

Benefit payments by the Plan are made at 85 per cent of the current fee schedule. Physicians must elect either to participate, that is accept all payments directly from the Plan, or not to participate. In either case physicians may extra-bill, but they must obtain written consent from the patient prior to rendering the service, and the amount of the extra charge has to be made known to the Commission.

The Nova Scotia plan is administered by a non-profit carrier which has been designated by the public authority as its sole agent with respect to fee-for-service accounts. This agency carries out all functions relating to eligibility checking and the processing and payment of claims, subject to review and audit by the public authority.

Manitoba - Manitoba began participating under the federal Medical Care Act on April 1, 1969. Enrolment is compulsory for all eligible residents but failure to pay the required premiums is not a barrier to receipt of insured services. Premium levies are $0.55 per month for single persons and $1.10 per month for families. Coverage of welfare recipients is automatic without premium payment. There are no premium subsidies because the premiums themselves are nominal.

The insured benefits cover all medically-required services provided by medical practitioners and limited dental surgery in hospitals. Also included, with limitations, are the services of chiropractors, and refractions by optometrists.

Physicians may elect to participate in the Plan, and to accept all payments from the public authority, or they may elect to receive payments direct from all their patients. In the former case the amount received (85 per cent of the fee schedule) must be accepted as payment in full. A non-participating physician must give a patient "reasonable notice" if he intends to extra-bill.

Alberta - Alberta became a participating province under the federal Medical Care Act on July 1, 1969, with administration

by a Health Care Insurance Commission. Registration, as in Saskatchewan, was compulsory for all eligible residents (except that failure to pay premiums was not a barrier to receipt of insured services) and the levels of benefits were similar to those in Saskatchewan for the services of doctors and oral surgeons. Additionally, the plan provided limited coverage for such paramedical services as refractions by optometrists, podiatry, chiropractic, and osteopathy. Doctors were paid at 100 per cent of the 1968 fee schedule of the medical association. Physicians could elect several modes of submitting claims for payment. In all instances, though, the Alberta doctors retained the right to extra-bill patients if they wish, subject to prior agreement by the patient.

Monthly premiums were $5.00 for single persons and $10.00 for families. No premium payment was required from welfare recipients. Subsidies reduced the premiums to $2.50 for single persons, and $5.00 per month for families, whose taxable income in the previous year did not exceed $500. There was also a provision that the provinces would pay up to full premiums for those residents who could prove financial need.

Substantial changes in the Alberta program became effective July 1, 1970. A combined annual premium of $69 for single persons and $138 for families was established to cover both medical and hospital insurance. Subsidies reduce the premiums to $24 for single persons and to $48 for families with no taxable income in the previous year; to $36 for single persons whose taxable income does not exceed $500; and to $72 for families whose combined taxable income does not exceed $1,000.

Registration and payment of applicable premiums is compulsory. Failure to comply makes householders liable, at time of seeking service, for payment of back premium levies, plus a penalty of 10 per cent of the unpaid premium, in order to ensure payment of the doctor's claim.

Residents objecting in principle to claiming benefits under the new program can now elect to remain outside the program (i.e. to "opt out") and not to be liable for premium payment. For hospital and related care, they are at liberty to obtain private insurance coverage but application of the federal Medical Care Act prevents private carriers from offering insurance for physicians' services.

The new plan also offers subscribers the option of purchasing insurance for additional health services (again, with subsidy provisions) from the voluntary Alberta Blue Cross agency. Rates applicable to non-group enrolees only are lower than

regular non-group coverage offered by this agency, but slightly higher than regular group rates. The optional membership offers coverage for hospital differential charges for semi-private and private ward care, ambulance services, drugs, appliances, home nursing care, naturopathic services, clinical psychological services, and dental care needed because of accidental injury.

Also, since July 1, 1970, payments to physicians have been made at 100 per cent of the 1969 fee schedule.

Ontario - Ontario began participating on October 1, 1969. Enrolment is compulsory for persons in specified employed groups and voluntary for others. The insured benefits currently cover all medically-required services of medical practitioners and of oral surgeons in specified hospital settings, and refractions by optometrists. Provision was made after July 1, 1970, for coverage, with limitations, of certain paramedical services offered by chiropractors, osteopaths, and podiatrists.

Payments are made at 90 per cent of the current fee schedule. Physicians may choose various modes of payments, but they are not required to enter into a formal commitment to confine themselves to any given mode. Regardless of the mode of payment selected, a physician is required to advise the patient of any intention to charge more than is provided under the Plan.

Premiums are $5.90 per month for single persons, $11.80 per month for 2-person families, and $14.75 for families of 3 or more. Coverage is automatic for welfare recipients and no premium payment is required for them. Subsidies for low-income families modify premiums as follows:

(1) No taxable income in the previous year -- full premium assistance (i.e., 100 per cent subsidy);

(2) Some taxable income --

- $2.95 per month (i.e., 50 per cent subsidy) for single persons if taxable income in previous year was $500 or less;

- $5.90 per month (i.e., 50 per cent subsidy) for 2-person families if combined taxable income in previous year was $1,000 or less;

- $5.90 per month (i.e., 60 per cent subsidy) for families of 3 persons or more if combined taxable income in previous year was $1,300 or less.

There are two additional provisions relating to financial aid. Three months' coverage is paid for families qualifying for temporary assistance, and recipients of Old Age Security pensions are entitled to full subsidy of premiums at permissible income levels higher than the ceilings set under the general subsidy program.

As in British Columbia, the public authority in Ontario makes use of administering agencies. In Ontario these agencies can be non-profit agencies or commercial insurance companies handling this component of their activities on a non-profit basis. Agencies can be "designated" or "participating" depending upon their degree of involvement in enrolment and claims-processing functions. Most of their enrolment is of employee and other groups. Additionally, the Ontario Health Services Insurance Plan itself enrols members and processes claims and covers the majority of non-group and subsidized beneficiaries.

Health Care Programs for Welfare Recipients

Provincial programs providing certain medical care and other health care benefits to recipients of welfare allowances were in operation in each province prior to the introduction of province-wide medical care insurance. Organized provincial schemes providing stipulated health services were introduced in Ontario in 1942; Saskatchewan in 1945; Alberta in 1947; British Columbia in 1949; Nova Scotia in 1950; Manitoba in 1960; Quebec in 1966; Prince Edward Island in 1966; and New Brunswick in 1967. Newfoundland has for many years operated a plan that provided care as required for persons in need. The total number of persons eligible for benefits under such programs are estimated to have reached 1,150,000 in the fiscal year 1967-68.

Hospital care insurance programs in every province provide automatic coverage to welfare allowance recipients without payment of premiums or co-charges by them.

Physicians' Services. - Following the implementation of public medical care insurance plans in the provinces of Saskatchewan, Alberta, British Columbia, Ontario, Manitoba, Nova Scotia, and Newfoundland provincial welfare recipients became automatically enrolled without premium payment. Under such programs for recipients of welfare, benefits and payment rates to physicians are identical to those applicable to the general population. Co-charges and extra-billing are usually waived.

Programs expressly covering welfare recipients and providing a virtually comprehensive range of physicians' services

continued, as of early 1970, in Quebec, New Brunswick and Prince Edward Island.

Provision of other health care benefits continues to follow a variety of patterns established under provincial or municipal programs, with costs now shared under the Canada Assistance Plan.

Prescribed-Drug Benefits. - In British Columbia, Alberta, Saskatchewan, New Brunswick, and Newfoundland virtually all provincial public assistance recipients are enrolled under schemes providing prescribed-drug benefits. In Manitoba a drug program covers persons designated as aged and infirm, recipients of mothers' allowances and their dependents, government wards, and indigent persons in unorganized territory. A variety of systems of drug benefit and non-benefit lists are employed and payment rates to pharmacies or dispensing physicians are negotiated by provincial governments. Under several schemes co-charges are levied on patients.

Drugs provided at local initiative in Ontario, Nova Scotia and Quebec are sharable under provincial legislation as well as under the Canada Assistance Plan and the Interim Arrangements Act.

Dental Care Benefits. - Dental benefit plans are operated for selected recipients of welfare in the four western provinces and in Ontario. In British Columbia, special means tests are applied to public assistance recipients in order to qualify them for enrolment. A separate program is operated in that province for the children under 13 years of age of all welfare recipients. The Ontario program provides dental benefits to persons in receipt of mothers' allowances and dependent fathers' allowances. This includes parents and their children under the age of 18. All provincial public assistance recipients qualify for dental benefits of schemes operated in Alberta and Saskatchewan.

Benefits under these dental plans typically exclude specified services and require prior authorization for some services. In the three westernmost provinces, posterior bridgework, prophylaxis and paedodontics are excluded. Prior authorization is required in British Columbia and Saskatchewan for dentures, relines, gold inlays, orthodontia and periodontia. Payments to dentists are at negotiated fixed rates under each of these plans. The patient is required to pay a co-charge of approximately 50 per cent of the cost of dentures in Alberta and Saskatchewan.

All dental care expenditures by municipalities in Ontario in respect to welfare recipients are shared by the province and through the Canada Assistance Plan.

A limited range of in-hospital dental surgery performed by physicians and dentists is a benefit under provincial medical care insurance plans.

Optical Care Benefits. - Health benefit schemes for welfare recipients included certain optical care services and eyeglasses in the four westernmost provinces.

With the implementation of public medical care insurance schemes in those provinces and in Nova Scotia, Ontario, and Newfoundland, refractions performed by physicians became general benefits under the schemes, and refractions by optometrists were also included except in Nova Scotia and Newfoundland. Thus previously-existing special authorization requirements for refractions in respect to welfare recipients were removed.

Frames, lenses and fittings continue to be benefits of the provincial health benefit schemes in the western provinces. Certain restrictions typically govern the amount which will be paid for frames, e.g., for cosmetic purposes.

Other Health Care Benefits. - Other health benefits which are provided under programs in some provinces include home nursing, appliances, physiotherapy, podiatry, chiropractic, and emergency transportation, usually at the discretion of the provincial authority. All such payments, including those initiated by municipalities, are sharable under the Canada Assistance Plan. Some of these benefits are now included under provincial medical care insurance plans.

Federal Programs. - Traditionally the federal government has provided a range of health benefits to needy war veterans, Indians and Eskimos.

These groups are now covered under provincial public hospital and medical insurance plans where such programs have been set up. In the remaining provinces the federal government continues to provide services directly and continues to provide such extended health care as is necessary where it is not among benefits of provincial health insurance programs.

Subsection 5 - Services for the Disabled and the Chronically Ill

The success of rehabilitation programs for injured workers, veterans, handicapped children, and other disability groups has encouraged more recent efforts to extend rehabilitation services to all handicapped persons. Physical medicine and rehabilitation departments have been established in the teaching hospitals and most veterans' and children's hospitals. There are about 40 children's hospitals and rehabilitation centres in the main cities; many children are also treated at general hospitals, or at rehabilitation centres that serve both adults and children. Five rehabilitation centres are operated under workmen's compensation programs.

Hospital services available to in-patients and out-patients include physical medicine, physiotherapy, occupational therapy, and social services; most of the children's hospitals and the teaching hospitals also supply speech therapy. The rehabilitation centres provide comprehensive medical, psychosocial, and vocational services to more-severely disabled persons. Provincial and community agencies providing rehabilitation and home care services co-operate in the rehabilitation of disabled persons.

Most large general hospitals conduct out-patient clinics for various diseases and disabilities, such as arthritis and rheumatism, diabetes, glaucoma, speech and hearing defects, heart diseases, and orthopedic and neurological conditions. Voluntary agencies concerned with such specific disability groups as arthritics, the blind, the deaf, children suffering from cystic fibrosis, haemophilia, or muscular dystrophy, the mentally ill or retarded, or disabled persons generally, are also broadening their rehabilitation services to include counselling, personal aids and appliances, transportation, employment and education, sheltered workshops and services for the homebound. Home care programs, under either hospital or community sponsorship, have been established in five provinces to provide nursing, homemaker, physiotherapy, and other services to the disabled, the chronically ill, the aged, and the convalescent.

Provincial health, welfare, and education departments and voluntary agencies are developing specialized services for physically and mentally handicapped children. Most provinces have registries of handicapped children, of varying coverage, and these are being found increasingly useful in the planning and co-ordination of rehabilitation services. In addition to medical rehabilitation, health departments and the crippled children's societies provide family counselling, recreation,

transportation, and foster home care; travelling clinics extend periodic diagnostic and treatment services to outlying areas. Special schools or classes for various groups of handicapped children are operated by local school boards in the main cities, but most of the 15 residential schools for the deaf and the six for the blind are operated under provincial auspices.

Regional prosthetic research and training units, supported by National Health Grants, have been set up in rehabilitation centres in Montreal, Toronto, and Winnipeg, and in the Bio-Engineering Institute of the University of New Brunswick. Artificial limbs and prosthetic appliances are made available in 12 prosthetic centres across Canada in accordance with provisions determined by provincial health departments. A federal-provincial program assists in meeting the extraordinary rehabilitation, maintenance, and counselling costs on behalf of children with thalidomide-induced defects.

Eleven university schools offer training in physical therapy and/or occupational therapy and four provide training in audiology and speech therapy.

In the year ended March 31, 1970, of the $30,900,290 made available through the general health grants to assist the provinces in their rehabilitation programs, $2,093,458 was specifically allocated to the Medical Rehabilitation and Crippled Children Grant. These grants are used to develop medical rehabilitation personnel through grants to the university schools and student bursaries, for equipment, and for research.

Section 4 - Emergency Health Services

In 1951 when the responsibility for civil defence was transferred from the Department of National Defence to the Department of National Health and Welfare, the Civil Defence Health Services group was formed within the Department to make plans for health services in a wartime emergency. In 1959, the Civil Defence Order assigned special powers and duties to several Ministers to prepare, and to assist the junior governments to prepare, for war emergencies (this order, as amended in 1963, was replaced in 1965 by the Civil Emergency Measures Planning Order) and the Canada Emergency Measures Organization was created to co-ordinate civil defence planning.

The Emergency Health Services Division, established in 1959 by the Minister of National Health and Welfare in his own department, encourages, with the support of an advisory

committee, the provinces to develop their own emergency health services divisions. These are organized under a provincial director who is generally assisted by a health-supplies officer and a nursing consultant. A staff medical officer represents the federal Emergency Health Services in each provincial organization.

The provincial emergency health services have four tasks: they ensure effective functioning of health services, so that vital health services will be maintained in an emergency or reorganized after a disaster; they encourage and co-ordinate local planning for the development of emergency medical units; they inform and educate the public through courses in first aid to the injured and in home nursing, and train professional health workers, students, and volunteers, for their functions during an emergency; and they dispose emergency medical units of the national stockpile at strategic locations.

Not all provincial and municipal health departments have developed their emergency planning to such an extent that they could function in a wartime disaster. Some, however, have planned their emergency measures so that they have been able to meet peacetime disasters successfully. Many emergency medical units have been strategically located, and the governments generally are agreed upon the objective of emergency health planning.

Section 5 - International Health

Canada actively assists and co-operates with the World Health Organization (WHO) and the other specialized agencies of the United Nations whose programs have a substantial health component or orientation. Canada's candidacy for re-election to the WHO Executive Board was successful by almost unanimous support at the 21st World Health Assembly. Capital and technical assistance are provided to developing countries through the Colombo Plan and other bilateral aid programs. Health training is provided for a number of persons coming to Canada each year under the various technical co-operation schemes; during 1967, there were 313 trainees in Canada studying in a wide range of health disciplines under the Canadian International Development Agency Program, but with greatest concentration in undergraduate medicine and in public health.

Canadian experts in health legislation, health administration, nursing, and related areas undertook specific

assignments abroad during the year and teachers and specialists in a number of clinical fields were provided in response to requests from developing countries. Capital assistance, primarily through the provision of Cobalt-60 beam therapy units for cancer treatment centres in the Colombo Plan area, was continued. As a result of the visit to Vietnam in 1967 of the Advisory Team on the Vietnam Medical Program, expanded tuberculosis, rehabilitation, immunization, hospital equipment, and other programs have been implemented.

To carry out Canada's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and medical care for persons arriving in Canada who require quarantine (see p. 9).

The Department is responsible for the enforcement of regulations governing the handling and shipping of shellfish under the International Shellfish Agreement between Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States as well as with problems caused by air pollution. Other responsibilities include the custody and distribution of biological, vitamin, and hormone standards for WHO and certain duties in connection with the Single Convention on Narcotic Drugs, 1961, as well as Canada's representation on the Narcotic Commission of the United Nations.

PART II - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Comprehensive income-maintenance measures such as the Canada Pension Plan, old age security pensions, the guaranteed income supplement, family allowances, youth allowances, and unemployment insurance, where nation-wide co-ordination is required, are administered federally. The federal government gives substantial aid to the provinces in meeting the costs of public assistance and also provides services for special groups such as veterans, Indians, Eskimos, and immigrants. The Department of National Health and Welfare is generally responsible for federal welfare matters although the Departments of Veterans Affairs, Indian Affairs and Northern Development, and Manpower and Immigration operate programs for specific groups.

Administration of welfare services is primarily the responsibility of the provinces but the provision of services is often assumed by local authorities, generally with financial aid from the province.

Section 1 - Federal Welfare Programs

Subsection 1 - Canada Pension Plan[1]

The Act establishing the Canada Pension Plan received Royal Assent on April 3, 1965 and was proclaimed in force on May 5 of the same year. Collection of contributions commenced in January 1966, in January 1967 the first benefits were paid in the form of retirement pensions, in February 1968 the first survivors' benefits were paid, and in February 1970 the first disability benefits were paid. The Plan represents an important milestone in Canadian social development. It will enable millions of people to make financial provision for their retirement and to protect themselves and their dependents or survivors against loss of income in the event of the disability or death of the head of the family.

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(1) Prepared by the Canada Pension Plan Administration.

The Plan is universally applicable throughout Canada, except in the Province of Quebec, where a comparable pension plan has been established. The Canada and Quebec Pension Plans are closely co-ordinated and operate virtually as a single program. Together, they cover almost all members of the labour force in Canada. Benefit credits accrued under the Canada or Quebec Plans are portable throughout Canada. A contributor who may have worked for more than one employer during his lifetime or who may be self-employed for all or part of his working life will accumulate pension credits regardless of where he may work in Canada. In addition, benefits under the Plan are payable to beneficiaries whether or not they live in Canada. Every contributor to the Plan must have a Social Insurance Number so that his pensionable earnings may be accurately recorded for benefit purposes.

The maximum pensionable earnings for a year were $5,000 for 1966 and 1967, $5,100 for 1968, $5,200 for 1969, and $5,300 for 1970. From 1971 to 1975, the figure of $5,300 will be adjusted in line with changes in the Pension Index which, in turn, is based on the Consumer Price Index. Beginning in 1976, the maximum pensionable earnings for a year will be adjusted in accordance with changes in the Earnings Index to reflect changes in average wage and salary levels in Canada.

To participate in the Plan, a person must be between the ages of 18 and 70 and earn more than $600 yearly as an employee, or at least $800 if he is self-employed. As of 1970, contributions are made on earnings between $600 and $5,300 a year in the case of both employees and self-employed persons. Employees contribute at the rate of 1.8 per cent and a matching contribution is made by their employers; self-employed persons contribute at the rate of 3.6 per cent. No contributions are to be made by persons while they are receiving disability pensions or after they commence to receive retirement pensions. Although contributions are made on annual earnings between $600 and the maxima referred to above, benefits are calculated on total earnings up to that maximum. That is, while contributions are not paid on the first $600 of annual earnings, that amount is nevertheless included in the calculation of benefits.

The earnings-related component of the benefit which a person is entitled to receive under the Canada Pension Plan is based on the contributor's average pensionable earnings. Before this average is calculated, however, all earnings are adjusted in line with the applicable maximum on pensionable earnings during the benefit year. Thus, when a benefit first becomes payable, the earnings on which it is based are related to the maximum on pensionable earnings at that time rather than to the maximum when the earnings were received.

Benefits are classified under three main headings: Retirement Pensions; Survivors' Benefits, consisting of a widow's pension, a disabled widower's pension, orphans' benefits, and a lump sum death benefit; and Disability Benefits comprising pensions for disabled contributors and benefits for their dependent children.

From 1970 on, Retirement Pensions are payable to contributors who are 65 years of age or over provided that, if under age 70, they were retired from regular employment. For contributors who have reached 70 years of age, retirement pensions are payable regardless of whether they are retired. They become payable at their full rate beginning in January 1976. This rate amounts to 25 per cent of what the updated pensionable earnings of contributors have averaged since January 1, 1966, or from age 18, whichever comes later.

Contributors who become eligible for retirement pensions prior to 1976 receive reduced amounts. In the calculation of Retirement Pensions that commence during this period, pensionable earnings are averaged over ten years or 120 months. The only exception is where a disability pension has been paid, in which case the time during which that pension was in pay is deducted from the ten years and the remaining period used for averaging purposes. In the calculation of retirement pensions that commence after 1975, provision is made to assist the contributor who may have had periods of low or no earnings during his contributory period. This is accomplished by dropping out the number of months during which contributions may have been made after age 65, and either by using the pensionable earnings in those months in place of earlier periods of lesser or no earnings, or by dropping such pensionable earnings out of the calculation if they are less favourable to him. Also dropped out of the calculation are up to 15 per cent of the number of months he could have contributed before age 65 and the earnings in an equal number of months, although the drop-out must not reduce the number of months for averaging purposes to less than 120.

A person under 70 years of age who is in receipt of a retirement pension must meet an earnings test. In 1970, the maximum annual remuneration from employment he may earn without affecting the amount of his pension is $900. Should his yearly earnings exceed this figure, his pension is reduced as follows. When annual employment earnings are between $900 and $1,500, the reduction will equal 50 per cent of the amount over $900, or an amount of up to $300 per year; if earnings exceed $1,500, the amount deducted will be $300 plus the actual amount earned over $1,500. However, the amount of pension is

not subject to reduction for any month in which the pensioner does not earn over $75. At age 70, a contributor is entitled to receive the full amount of his retirement pension regardless of the amount of his earnings.

Survivors' Benefits became payable in February 1968. They are paid to or on behalf of the survivors of a deceased contributor who has made contributions for the minimum qualifying period, which is three years for those whose benefits commence before 1975.

A woman who is widowed between ages 45 and 65 is entitled to a widow's pension consisting of a flat-rate component plus 37½ per cent of her husband's retirement pension. The flat-rate component is equal to $25 multiplied by the ratio of the Pension Index for the year in which the contributor dies to the Pension Index for 1967. Thus, for 1970, the flat-rate component is $26.53. Should her husband not be in receipt of a retirement pension at the time of his death, such a pension is calculated in prescribed manner for the purposes of computing the amount of the widow's pension. If a woman is widowed under age 45, the same pension is paid provided she has dependent or disabled children or is herself disabled. If she does not meet any of these requirements, her pension is reduced by an amount equal to 1/120 for each month she is less than age 45 at the time of her husband's death. Accordingly, if a woman is widowed at age 35 or less, and has no dependent or disabled children and is not herself disabled, she will not receive a widow's pension until she reaches 65 years of age, unless she becomes disabled in the meantime.

A widow aged 65 or over receives a widow's pension equal to 60 per cent of her husband's retirement pension, regardless of her age at the time her husband died or whether she was receiving a widow's pension before she became 65. Again, if her husband was not in receipt of a retirement pension at the time of his death, one is calculated in prescribed manner in order to compute the amount of the widow's pension. Women who receive widow's pensions may also have contributed to the Canada Pension Plan themselves and consequently may be entitled to retirement or disability pensions in their own right. In such cases, the widow's pension will be combined with the other pension, in accordance with a prescribed formula, but the combined total cannot exceed the maximum retirement pension payable under the Act.

Orphan's benefits are payable on behalf of a deceased contributor's unmarried dependent children. The rate for each of the first four children is equal to the flat-rate

component of the widow's pension ($26.53 for 1970); for more than four children the total benefit, which is divided equally among the children, is the sum of $26.53 for each of four and half of that amount for each child in excess of four. Benefits are payable until the child reaches age 18 or up to age 25 if he continues to attend school or university full time.

A disabled widower's pension is payable where he was wholly or substantially dependent on his wife for financial support at the time of her death. The test of disability is the same as that for a person who claims a disability pension and the pension formula is the same as that for a disabled widow.

When a contributor dies, a lump sum death benefit equal to six times his monthly retirement pension will be paid to his estate. This benefit is subject to a maximum of 10 per cent of the maximum pensionable earnings which, for 1970, would mean a payment not exceeding $530. Should a contributor not be in receipt of a retirement pension at the time of his death, a calculation is made in prescribed manner for purposes of establishing the amount of the death benefit.

Disability Pensions became payable in 1970. A contributor is considered to be disabled if he has a physical or mental disability that is so severe and likely to continue so long that he cannot regularly engage in any substantially gainful occupation. Disability pensions, plus benefits for the dependent children of disabled contributors, are available provided contributions have been made to the Plan for the required minimum period, which is for five years for contributors whose disability pensions will commence before 1976. The amount of the pension consists of a flat-rate payment equal to the flat-rate component of a widow's pension plus 75 per cent of what the contributor's monthly retirement pension would have been had he reached age 65 when his disability pension commenced. Benefits are payable on behalf of a disabled contributor's dependent children at the same rates and under essentially the same circumstances as the orphan's benefits.

All monthly benefits are adjusted upwards annually if the changes in the Pension Index warrant it. Benefits in payment in 1967 were increased by two per cent effective January 1968, those in payment in 1968 were increased by two per cent effective January 1969, and those in payment in 1969 were increased by two per cent effective January 1970.

Any contributor or beneficiary under the Plan has the right to appeal decisions with which he is dissatisfied. Appeals by employees and employers regarding coverage and contributions are first made to the Minister of National Revenue and, if the individual is not satisfied with the Minister's decision, he may appeal to the Pension Appeals Board whose decision is final. For self-employed persons, appeals with reference to the assessment of their earnings for Canada Pension Plan purposes are treated in the same way as appeals under the Income Tax Act. With respect to benefits, there is a three-stage appeal procedure: first, to the Minister of National Health and Welfare; secondly, to a Review Committee; and thirdly, to the Pension Appeals Board whose decision is final.

The legislation provides for the investment of the funds that accrue from monthly contributions, less the estimated amounts required to pay benefits and administrative costs over a three-month period. These funds are made available to each province on the basis of the relationship between the contributions made to the Plan by and on behalf of residents of that province and the total contributions made to the Plan. Funds not borrowed by the provinces are invested in federal securities. The Canada Pension Plan is entirely self-supporting in that all benefits and all costs incurred in the administration of the program are financed solely from the contributions made by employees, employers, and self-employed persons and the interest earned from the investment of funds.

An Advisory Committee representing employers, employees, self-employed persons, and the public, which was established in 1967, reviews from time to time the overall operations of the Plan, the state of the Investment Fund, and the adequacy of coverage and benefits; and reports to the Minister of National Health and Welfare. In addition, a report on its activities is included in the Annual Report on the Plan. The legislation authorizes arrangements to be made with other countries to achieve as full coverage of persons in the labour force in Canada as is possible and to ensure the portability of pension credits between Canada and the countries concerned.

The Minister of National Health and Welfare is responsible for the administration of all parts of the program except coverage and the collection of contributions, which come under the jurisdiction of the Minister of National Revenue.

The Unemployment Insurance Commission is responsible for the assignment of Social Insurance Numbers and for the maintenance of the Central Index. The Department of Finance is responsible for the administration of the Canada Pension Plan Account and the Canada Pension Plan Investment Fund. The Department of Supply and Services gives temporary assistance to the Department of National Health and Welfare in the operation of the electronic data processing service which is required to maintain the Records of Earnings of contributors and to calculate benefits payable under the Plan. The Chief Actuary, Department of Insurance, is responsible for the preparation of reports on the future financial progress of the Plan and on the effect on the Fund of proposed amendments to the Plan.

The Canada Pension Plan Administration of the Department of National Health and Welfare consists of a head office establishment in Ottawa and a network of 38 District Offices located in the major population centres in Canada outside the Province of Quebec and 104 local offices, the latter on a part-time basis.

Tables 14 to 20 set out statistics of the Canada Pension Plan.

Subsection 2 - Old Age Security

Under the Old Age Security Act of 1951, as amended, the Federal Government pays a monthly pension to all persons aged 65 or over who meet the necessary residence and age qualifications. Until 1966 the pension was payable to those aged 70 or over but an annual one-year reduction in pensionable age from 70 to 65 was completed in 1970. Until 1967, the pension amounted to $75 a month but, in 1968 and succeeding years, the amount of the pension may be adjusted in line with changes in the Pension Index developed for the Canada Pension Plan; it reached $79.58 in January 1970.

The Old Age Security pension is payable to a person of attained age who has resided in Canada for ten years immediately preceding the approval of his application for the pension. Any gaps in the ten-year period may be off-set if the applicant had been present in Canada in earlier years for periods of time equal in total to double the length of the gaps; in this case, however, the applicant must also have resided in Canada for one year immediately before the month in which his application for pension may be approved. The pension is also payable to

TABLE 14 - CANADA PENSION PLAN ACCOUNT: STATEMENT OF REVENUE AND EXPENDITURE, FISCAL YEARS 1965-66 TO 1969-70

(Million Dollars)

Period	REVENUE				EXPENDITURE[a]			Excess of Revenue	Balance in CPP Account
	Contributions	Interest on Investments	Other	Total	Benefits	Administration	Total		
1965-66	94.9	-	-	94.9	-	5.5	5.5	89.4	89.4
1966-67	587.2	11.0	1.7	599.9	-	8.4	8.4	591.5	680.9
1967-68	640.2	42.2	2.2	684.7	1.3	11.5	12.8	671.9	1,352.8
1968-69	697.6	84.4	3.0	785.0	15.6	14.5	30.0	755.0	2,107.8
1969-70[b]	745.6	139.7	4.1	889.5	47.3	16.3	63.6	825.9	2,933.3

(a) net.

(b) Preliminary data.

NOTE: Due to rounding, data may not add to totals shown.

TABLE 15 - CANADA PENSION PLAN INVESTMENT FUND:
INVESTMENTS BY PROVINCE,
FISCAL YEARS 1965-66 TO 1969-70

(Million Dollars)

Securities of or Guaranteed By	FISCAL YEAR					All Fiscal Years
	1965-66	1966-67	1967-68	1968-69	1969-70	
	Investments Made in Period					
Newfoundland	0.7	11.0	12.0	14.2	15.6	53.5
P.E.I.	0.1	1.9	2.3	2.9	3.2	10.4
Nova Scotia	1.2	21.4	25.2	29.2	31.6	108.7
New Brunswick	1.0	16.7	19.3	21.8	24.2	83.0
Quebec	-	0.4	1.9	2.4	3.1	7.7
Ontario	20.1	332.6	375.9	412.0	445.8	1,586.4
Manitoba	2.1	34.9	39.4	42.3	47.7	166.3
Saskatchewan	1.4	24.5	29.7	35.9	40.4	131.8
Alberta	3.1	51.1	59.2	68.4	77.1	258.8
British Columbia	5.1	84.4	96.6	107.5	117.2	410.7
Canada	0.1	1.8	3.8	5.6	4.1	15.4
All Jurisdictions	34.9	580.7	665.3	742.2	809.8	2,832.7
	Balance in Fund at End of Period					
All Jurisdictions	34.9	615.5	1,280.8	2,022.9	2,832.7	-

NOTE: Due to rounding, data may not add to totals shown.

TABLE 16 - CANADA PENSION PLAN BENEFITS PAID IN MONTH: NUMBER OF BENEFICIARIES, BY TYPE OF BENEFIT, BY MONTH, MARCH 1969 TO MARCH 1970

Month	Retirement Pensions	Widow's Pensions	Disabled Widower's Pensions	Benefits For		Combined Pensions	Death Benefits	All Benefits
				Orphans Under Age 18	Orphans Age 18 and Over			
1969								
March	58,374	7,066	5	6,783	1,923	10	1,222	75,383
April	62,459	8,080	7	7,668	2,202	10	1,646	82,072
May	66,427	9,823	8	9,155	2,699	10	1,832	89,954
June	69,975	10,622	11	10,679	1,996	10	1,617	94,910
July	73,911	11,983	15	11,957	2,266	10	1,607	101,749
August	76,696	13,106	17	12,981	2,450	10	1,266	106,526
September	79,106	14,676	19	14,547	2,653	10	1,585	112,596
October	84,072	16,047	19	15,759	2,924	10	1,597	120,428
November	86,797	17,110	20	16,765	3,268	10	1,704	125,673
December	90,064	17,998	23	17,511	3,530	10	1,263	130,399
1970								
January	103,756	18,649	23	18,026	3,622	10	1,385	145,471
February	109,313	19,368	23	18,685	3,583	10	1,457	152,439
March	114,939	20,952	23	20,040	3,925	10	1,941	161,830

NOTE: During the month of March 1970, 100 disability pensions were paid, as well as 85 benefits for children of disabled contributors.

TABLE 17 - CANADA PENSION PLAN BENEFITS PAID IN MONTH: NUMBER OF BENEFICIARIES, BY TYPE OF BENEFIT, BY PROVINCE

MARCH 1970

Province	Retirement Pensions	Widow's Pensions	Disabled Widower's Pensions	Benefits For		Combined Pensions	Death Benefits	All Benefits
				Orphans Under Age 18	Orphans Age 18 and Over			
Newfoundland	1,915	370	0	642	77	0	34	3,038
P.E.I.	685	119	0	192	33	0	17	1,046
Nova Scotia	5,118	1,157	2	1,298	245	0	89	7,909
New Brunswick	3,830	855	1	1,063	203	0	72	6,024
Quebec	426	144	1	176	28	0	10	785
Ontario	60,907	11,316	9	9,399	2,072	8	1,127	84,838
Manitoba	8,697	1,334	2	1,211	247	1	119	11,611
Saskatchewan	6,559	1,146	3	1,235	201	0	106	9,250
Alberta	9,424	1,792	2	2,097	367	0	150	13,832
British Columbia	17,323	2,700	3	2,694	450	1	214	23,385
Yukon	31	14	0	20	1	0	2	68
N.W.T.	24	5	0	13	1	0	1	44
All Areas	114,939	20,952	23	20,040	3,925	10	1,941	161,830

NOTE: During the month of March 1970, 100 disability pensions were paid, as well as 85 benefits for children of disabled contributors.

TABLE 18 - CANADA PENSION PLAN BENEFITS PAID IN MONTH: PAYMENTS, BY TYPE OF BENEFIT, BY PROVINCE, FISCAL YEAR 1969-70

(Thousand Dollars)

Province	Retirement Pensions	Widow's Pensions	Disabled Widower's Pensions	Benefits For		Combined Pensions	Death Benefits	All Benefits
				Orphans Under Age 18	Orphans Age 18 and Over			
Newfoundland	241.8	227.4	-	167.1	27.6	-	128.3	792.2
P.E.I.	74.1	70.5	-	48.2	12.6	-	43.0	248.4
Nova Scotia	704.9	719.3	1.1	363.1	87.3	-	403.3	2,279.0
New Brunswick	525.5	506.7	0.6	282.5	68.6	-	286.3	1,670.2
Quebec	76.7	102.9	0.6	54.0	10.3	-	40.7	285.2
Ontario	10,030.5	7,715.6	7.0	2,772.9	748.9	5.4	4,657.4	25,937.7
Manitoba	1,252.7	899.7	1.2	357.9	92.5	0.4	547.0	3,151.4
Saskatchewan	979.1	819.7	2.1	402.7	77.9	-	472.3	2,753.8
Alberta	1,381.8	1,203.5	1.5	618.0	137.5	-	717.5	4,059.8
British Columbia	2,659.1	1,898.0	1.5	805.9	170.9	0.6	1,123.8	6,659.8
Yukon	7.1	12.3	-	7.4	0.3	-	11.7	285.2
N.W.T.	4.3	4.7	-	4.9	-	-	2.2	16.1
All Areas	17,937.6	14,180.3	15.7	5,885.0	1,435.0	6.4	8,433.5	47,895.6

NOTE: Due to rounding, data may not add to totals shown.

During the month of March 1970, $15,837.84 was paid in disability pensions, as well as $4,244.98 in benefits for children of disabled contributors.

TABLE 19 - CONTRIBUTORS TO THE CANADA AND QUEBEC PENSION PLANS, BY PROVINCE AND BY SEX, FOR 1966, 1967 AND 1968[a]

PROVINCE	NUMBER OF CONTRIBUTORS								
	MALE			FEMALE			TOTAL[b]		
	1966	1967	1968	1966	1967	1968	1966	1967	1968
Newfoundland	91,588	88,566	90,979	26,636	25,377	27,983	119,718	114,323	119,174
Prince Edward Island	17,956	17,824	18,276	7,345	7,268	7,823	25,677	25,176	26,148
Nova Scotia	155,419	153,542	158,487	62,861	59,924	64,006	219,593	213,776	222,666
New Brunswick	121,814	120,794	122,993	49,571	46,930	51,205	172,577	168,013	174,383
Quebec	1,254,755	1,272,649	1,124,677	521,413	537,398	519,075	1,786,060	1,814,087	1,646,171
Ontario	1,827,027	1,837,824	1,705,487	902,270	876,859	887,720	2,744,131	2,719,453	2,596,646
Manitoba	220,765	221,581	225,958	105,960	101,915	107,627	328,743	324,080	333,968
Saskatchewan	215,126	215,862	212,873	76,732	73,793	77,317	294,018	290,223	290,540
Alberta	345,630	353,416	365,657	153,667	151,716	163,831	502,593	506,094	530,178
British Columbia	488,142	494,206	492,632	214,542	209,997	221,099	706,782	705,354	714,451
Northwest Territories	5,750	5,588	5,869	1,727	1,810	2,030	7,845	7,463	7,959
Yukon	3,775	3,963	4,709	1,636	1,652	1,850	5,471	5,648	6,568
CANADA[c]	4,747,747	4,785,815	4,528,597	2,124,360	2,094,639	2,131,566	6,913,208	6,893,690	6,668,852

(a) These data include only those contributors who filed income-tax returns.

(b) Includes contributors for whom sex was not stated. There were 8,689 of these in the 1968 data.

(c) The apparent trend in these totals may be misleading, because a considerable number of non-contributors were erroneously included. This is especially true in the earlier years.

TABLE 20 - AVERAGE INCOME OF CONTRIBUTORS TO THE CANADA PENSION PLAN AND QUEBEC PENSION PLAN, BY PROVINCE, CALENDAR YEAR 1968

Province	Average Income of:		
	Male Contributors	Female Contributors	All Contributors
	$	$	$
Newfoundland	4,863	2,701	4,352
Prince Edward Island	4,266	2,672	3,788
Nova Scotia	5,118	3,013	4,511
New Brunswick	4,927	2,861	4,319
Quebec	6,929	3,795	5,936
Ontario	7,597	3,793	6,293
Manitoba	5,821	3,183	4,969
Saskatchewan	5,389	3,211	4,808
Alberta	6,203	3,343	5,317
British Columbia	7,027	3,552	5,950
Yukon Territory	7,574	3,952	6,551
Northwest Territories	6,425	3,744	5,715
Canada	6,835	3,618	5,804

persons of attained age who have left Canada before reaching that age but who have had 40 years of residence in Canada since age 18. A pensioner may absent himself from Canada and continue to receive payments. If he has lived in Canada for 25 years since his 21st birthday, payment outside of Canada may continue indefinitely; if not, payment is continued for six months, in addition to the month of departure, and is then suspended, to be resumed only with the month in which he returns to Canada.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital, to which application is made for pension. The regional office in Edmonton administers accounts for and receives applications from residents of the Yukon and the Northwest Territories. The Old Age Security plan is financed through a 3 per cent sales tax, a 3 per cent tax on corporation income and, subject to a limit of $240 a year, a 4 per cent tax on taxable personal income. The revenues from these sources are paid into a separate fund called the Old Age Security Fund, from which are paid the Old Age Security pensions and, from January 1, 1967, benefits under the Guaranteed Income Supplement program. Tables 21 and 22 provide statistics of the Old Age Security program.

Guaranteed Income Supplement. - A 1966 amendment to the Old Age Security Act provides for the payment of a monthly guaranteed income supplement to Old Age Security pensioners who have little or no income other than the pension. The supplement is limited to pensioners born on or before December 31, 1910, who by reason of age are or will be unable to benefit substantially from the Canada or Quebec Pension Plans. The program commenced on January 1, 1967. Beginning at that date, the maximum supplement was $30 a month; in any year after 1967, it is to be 40 per cent of the amount of the flat-rate Old Age Security pension. With the escalation of the latter pension effected January 1970, the maximum supplement was increased to $31.83 a month. Thus, pensioners with only the Old Age Security pension receive a guaranteed annual income of $1,336.92 for a single pensioner and, for a married couple who are both pensioners, $2,673.84. This consists of the monthly $79.58 pension and the monthly supplement of $31.83 which is subject to an income test.

Pensioners with income in addition to their old age security pension may receive partial benefits. The maximum supplement is reduced by $1 a month for every full $2 a month of income over and above the Old Age Security pension

TABLE 21 - OPERATIONS OF THE OLD AGE SECURITY FUND, YEARS ENDED MARCH 31, 1964 TO 1969

Item	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69
	$	$	$	$	$	$
Source of funds:						
Sales tax	331,760,067	383,151,254	522,085,844	559,515,046	544,516,013	528,121,864
Corporation income tax	115,750,000	145,250,000	152,250,000	149,500,000	150,000,000	183,000,000
Individual income tax	302,600,000	431,900,000	494,900,000	576,600,000	800,100,000	915,000,000
Loan from consolidated revenue fund	58,281,233	-	-	-	-	-
Balance brought forward	-	-	-	216,982,842	429,592,180	536,089,248
Total	808,391,300	960,301,254	1,169,235,844	1,502,597,888	1,924,208,193	2,162,211,112
Application of funds:						
Benefit payments	808,391,300	885,294,468	927,299,487	1,073,005,708 (a)	1,388,118,945 (a)	1,541,319,549 (a)
Repayment of loans to consolidated revenue fund	-	75,006,786	24,953,515	-	-	-
Balance carried over	-	-	216,982,842	429,592,180	536,089,248	620,891,563
Total	808,391,300	960,301,254	1,169,235,844	1,502,597,888	1,924,208,193	2,162,211,112

(a) Includes payments under the Guaranteed Income Supplement program amounting to $39,597,478 in 1966-67, $234,835,151 in 1967-68, and $244,470,268 in 1968-69.

TABLE 22 - OLD AGE SECURITY STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1969

Province and year	Pensioners in March	Net pensions paid during fiscal year	Province and year	Pensioners in March	Net pensions paid during fiscal year
	No.	$		No.	$
Newfoundland.....1964	18,477	15,376,636	Manitoba.....1964	58,850	48,874,928
1965	18,886	16,811,166	1965	59,818	53,360,235
1966	21,184	17,586,159	1966	65,758	55,494,509
1967	23,733	19,706,767	1967	71,471	60,767,093
1968	25,865	23,971,795	1968	78,147	66,781,367
1969	28,702	24,898,913	1969	85,297	73,990,080
1970	31,628	27,962,478	1970	93,497	82,432,414
Prince Edward Island....1965	7,949	7,118,615	Saskatchewan.....1965	61,257	55,063,268
1966	8,809	7,447,170	1966	66,638	56,755,191
1967	9,665	8,207,258	1967	71,892	61,478,838
1968	10,458	9,542,231	1968	77,725	66,153,435
1969	11,411	10,023,447	1969	84,295	73,805,638
1970	12,285	10,991,947	1970	92,168	82,051,152
Nova Scotia.....1965	45,014	40,399,804	Alberta.....1965	67,245	60,052,938
1966	49,801	42,048,599	1966	74,514	62,793,976
1967	54,690	46,533,160	1967	82,145	69,524,557
1968	59,363	52,783,504	1968	91,118	77,574,022
1969	64,438	56,489,364	1969	100,895	86,675,340
1970	70,004	62,651,195	1970	112,921	96,818,953
New Brunswick.....1965	33,262	29,780,719	British Columbia.....1965	124,262	111,327,361
1966	36,852	30,994,768	1966	135,556	115,292,880
1967	40,565	34,358,253	1967	147,930	125,662,029
1968	44,390	39,418,789	1968	161,341	135,848,974
1969	48,424	42,465,412	1969	177,382	154,191,907
1970	52,935	47,287,051	1970	194,709	172,400,945
Quebec.....1965	214,294	189,682,327	Yukon and Northwest Territories....1965	707	633,415
1966	242,865	201,031,152	1966	802	660,570
1967	275,515	228,797,146	1967	886	744,905
1968	309,447	267,445,266	1968	1,015	962,396
1969	348,901	297,931,760	1969	1,144	968,859
1970	394,138	342,436,313	1970	1,243	1,077,330
Ontario.....1965	360,888	321,064,620	Canada.....1965	993,582	885,294,468
1966	402,997	337,194,513	1966	1,105,776	927,299,487
1967	451,069	377,628,224	1967	1,229,561	1,033,408,230
1968	507,341	412,802,015	1968	1,366,210	1,153,283,794
1969	553,973	475,408,561	1969	1,504,862	1,296,849,281
1970	615,111	540,908,249	1970	1,670,639	1,467,056,517

that may have been received. Income for this purpose is the same as that computed in accordance with the Income Tax Act. In the case of a married couple, each is considered to have one-half of their combined income. Where one spouse will not be receiving an Old Age Security pension at any time in the current year, six times the amount of the monthly Old Age Security pension is deducted from one-half of the combined income in calculating the income of the pensioner for Guaranteed Income Supplement purposes.

Payments will not be made to married couples unless both spouses submit returns. However, in order to prevent undue hardship when no statement of income is obtainable from one spouse, the other, in certain circumstances, may be deemed to be single for purposes of determining income. Furthermore, although marital status is determined as at December 31 of the preceding year, even if this status should change in the current year, a special provision allows a person to be deemed either married or single in the preceding year.

If a pensioner who is in receipt of a supplement leaves Canada, the supplement will be paid for the month of departure and for six further months. Payment will then be discontinued until his return.

The guaranteed income supplement program is administered in conjunction with the Old Age Security pension program. An application for the supplement is sent to each person when he begins to receive the Old Age Security pension and subsequently at the beginning of each calendar year. Entitlement is reassessed each year on the basis of the pensioner's income in the preceding year.

Statistics of the operations of the Guaranteed Income Supplement program appear in Tables 23 to 29.

Subsection 3 - Family Allowances

The Family Allowances Act of 1944 assists in providing equal opportunity for all Canadian children. The allowances do not involve a means test and are paid from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances.

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been

TABLE 23 - GUARANTEED INCOME SUPPLEMENT PENSIONERS AND PAYMENTS, BY PROVINCE, YEARS ENDED MARCH 31, 1967 TO 1970

Province and year	Pensioners in March	Net Supplements Paid During Fiscal Year (a)	Province and year	Pensioners in March	Net Supplements Paid During Fiscal Year (a)
	No.	$		No.	$
Newfoundland.....1967	18,037	1,520,404	Manitoba.....1967	35,633	2,731,259
1968	21,165	4,873,628	1968	44,323	13,587,590
1969	23,004	7,378,966	1969	46,248	14,369,685
1970	24,835	8,412,681	1970	47,575	15,545,125
Prince Edward Island....1967	6,444	521,776	Saskatchewan.....1967	33,132	2,545,612
1968	7,801	1,941,171	1968	40,564	13,463,882
1969	8,285	2,564,376	1969	41,711	13,099,339
1970	8,612	2,776,288	1970	43,846	14,197,485
Nova Scotia.....1967	30,613	2,464,576	Alberta.....1967	36,526	2,863,528
1968	38,230	10,739,242	1968	50,267	15,788,848
1969	40,005	12,767,582	1969	53,927	17,270,807
1970	41,408	13,467,226	1970	56,893	20,387,664
New Brunswick.....1967	21,937	1,795,836	British Columbia.....1967	57,922	4,421,545
1968	28,691	8,026,962	1968	79,674	27,664,511
1969	30,182	9,555,197	1969	82,716	25,784,016
1970	31,730	10,432,556	1970	85,552	27,401,086
Quebec.....1967	136,306	10,968,346	Yukon and Northwest Territories....1967	51	3,127
1968	187,943	54,423,691	1968	761	198,531
1969	207,869	66,181,574	1969	829	296,820
1970	224,409	73,375,872	1970	876	328,230
Ontario.....1967	128,639	9,761,469	Canada.....1967	505,240	39,597,478
1968	215,229	84,127,095	1968	714,648	234,835,151
1969	240,258	75,201,906	1969	775,034	244,470,268
1970	247,099	77,154,415	1970	812,835	263,478,628

(a) 1967 figures cover three months; program became effective January 1, 1967.

TABLE 24 - NUMBERS AND PERCENTAGES OF THE POPULATION RECEIVING GIS AS OF JANUARY 1, 1967 AND 1968, BY SEX AND AGE(a)

Sex and Age	As of January 1, 1967				As of January 1, 1968			
	Number	Per cent of population(b) receiving GIS and			Number	Per cent of population(c) receiving GIS and		
		Without other income(d)	With other income(d)	Total		Without other income(e)	With other income(e)	Total
Male								
67(f)	0	0.0	0.0	0.0	14,120	15.5	11.8	27.3
68	14,610	17.6	13.8	31.4	12,985	15.8	10.8	26.6
69	14,420	18.3	14.2	32.5	13,815	18.5	11.2	29.7
70 - 74	79,070	21.4	18.4	39.8	73,970	20.9	16.1	37.0
75 - 79	71,725	27.6	24.0	51.6	70,775	28.0	22.4	50.4
80 - 84	45,795	31.6	25.2	56.8	47,790	34.4	24.3	58.7
85 - 89	20,905	38.9	24.3	63.2	20,900	37.9	23.2	61.1
90 - 94	5,440	41.0	22.6	63.6	5,915	47.2	20.0	67.2
95 plus	1,320	63.1	22.0	85.1	1,175	49.7	23.7	73.4
All ages	253,285	25.3	20.5	45.8	261,445	24.7	17.9	42.6
Female								
67(f)	0	0.0	0.0	0.0	20,935	26.9	10.4	37.3
68	21,695	30.2	11.2	41.4	18,910	25.4	9.4	34.8
69	21,285	29.7	12.2	41.9	21,500	29.7	11.4	41.1
70 - 74	111,805	33.0	16.0	49.0	113,450	34.0	14.7	48.7
75 - 79	97,045	40.4	19.7	60.1	98,955	39.8	19.5	59.3
80 - 84	65,130	45.0	22.4	67.4	68,715	46.4	22.4	68.8
85 - 89	30,455	47.0	22.7	69.7	33,625	51.3	22.8	74.1
90 - 94	9,715	53.9	19.7	73.6	10,560	54.0	22.0	76.0
95 plus	2,265	63.1	16.3	79.4	2,700	73.1	16.6	89.7
All ages	359,395	37.6	17.7	55.3	389,350	37.2	16.5	53.7
Both sexes								
67(f)	0	0.0	0.0	0.0	35,055	21.4	11.1	32.5
68	36,305	24.3	12.4	36.7	31,895	20.8	10.1	30.9
69	35,705	24.3	13.2	37.5	35,315	24.4	11.3	35.7
70 - 74	190,875	27.6	17.1	44.7	187,420	28.0	15.3	43.3
75 - 79	168,770	34.5	21.7	56.2	169,730	34.5	20.8	55.3
80 - 84	110,925	38.9	23.7	62.6	116,505	41.0	23.3	64.3
85 - 89	51,360	43.6	23.3	66.9	54,525	45.5	23.0	68.5
90 - 94	15,155	48.9	20.8	69.7	16,475	51.4	21.2	72.6
95 plus	3,585	63.1	18.3	81.4	3,875	65.0	19.1	84.1
All ages	612,680	32.0	19.0	51.0	650,795	31.4	17.2	48.6

(a) Based on samples of GIS applications.
(b) Based on 1966 Census data, which give age at last birthday prior to June 1, 1966.
(c) Based on intercensal estimate of population as of June 1, 1967, by the Dominion Bureau of Statistics.
(d) That is, exclusive of Old Age Security (OAS) during the previous calendar year.
(e) That is, exclusive of OAS and GIS during the previous calendar year.
(f) Not eligible for either OAS or GIS at age 67 years in 1967.

TABLE 25 - INCOME STATUS DURING PREVIOUS YEAR OF OAS PENSIONERS RECEIVING GIS AS OF JANUARY 1, 1967 AND 1968, BY SEX, AGE, AND MARITAL STATUS(a)

Sex and Age	Not-married(b) pensioners				Married pensioners in two-pensioner families				Married pensioners in one-pensioner families			
	Per cent with income(c)		Average(d) income(c)		Per cent with income(c)		Average(d) income(c)		Per cent(e) with income(c)		Average(d) income(c,e)	
	1966(f)	1967	1966	1967	1966	1967	1966	1967	1966	1967	1966	1967
	%	%	$	$	%	%	$	$	%	%	$	$
Male												
67(g)	-	26.6	-	259	-	53.8	-	575	-	54.6	-	970
68	29.3	26.3	260	227	49.6	45.4	453	579	54.5	52.0	918	803
69	30.9	24.6	244	284	50.8	42.7	497	568	51.9	46.9	825	783
70 - 74	33.3	31.7	262	244	53.2	53.6	509	474	54.0	47.0	772	766
75 - 79	36.9	34.0	257	254	55.1	52.5	474	481	48.5	45.7	694	612
80 - 84	36.2	33.9	246	245	53.0	49.2	418	425	47.8	42.7	539	701
85 - 89	34.3	35.6	258	223	47.6	43.3	329	400	27.0	24.1	594	537
90 - 94	32.6	24.0	226	248	44.1	45.7	365	334	33.3*	54.5*	371	1,153*
95 plus	24.6	28.3	275	215	25.0*	55.2*	566*	257*	100.0*	50.0*	152	303*
All ages	34.6	32.0	254	245	53.1	50.9	461	466	52.1	47.8	771	774
Female												
67(g)	-	29.1	-	283	-	26.5	-	246	-	23.2	-	439
68	30.0	29.0	281	235	24.6	24.6	216	276	12.9	18.8*	147	184*
69	33.2	32.0	229	263	23.7	21.4	262	216	8.1*	16.7	439*	175
70 - 74	35.0	31.7	259	243	27.6	27.3	207	207	28.0	18.3	248	525
75 - 79	33.8	33.5	260	238	29.7	30.6	205	201	12.8*	30.8	343*	478
80 - 84	34.1	33.2	248	237	29.2	29.7	177	230	0.0*	0.0*	0*	0*
85 - 89	32.9	30.7	227	230	27.8	32.1	177	167	0.0*	0.0*	0*	0*
90 - 94	27.2	29.3	207	177	20.5	21.1	190	101	- *	- *	- *	- *
95 plus	21.1	17.7	178	175	0.0*	40.0*	0*	295*	0.0*	- *	0*	- *
All ages	33.6	31.9	249	239	27.7	27.8	206	214	18.5	20.6	250	408
Both sexes												
67(g)	-	28.3	-	276	-	32.2	-	361	-	49.9	-	933
68	29.8	28.2	275	233	29.2	29.6	291	388	48.6	49.7	889	786
69	32.6	29.9	233	268	30.9	27.5	365	373	47.4	43.9	819	760
70 - 74	34.6	31.7	268	244	38.7	38.3	386	363	52.1	45.4	751	760
75 - 79	34.7	33.7	259	242	44.4	43.5	398	400	46.9	45.1	690	608
80 - 84	34.7	33.4	248	239	45.3	42.5	367	378	47.3	42.0	539	701
85 - 89	33.3	32.2	238	228	42.3	40.0	302	346	26.7	23.2	594	537
90 - 94	28.8	27.7	213	195	37.0	40.5	336	308	33.3*	54.5*	371*	1,153*
95 plus	22.3	20.6	214	190	19.5*	49.0	566*	539	50.0*	50.0*	152*	303*
All ages	33.9	32.0	252	241	40.8	39.4	377	378	49.5	45.9	756	762

(a) Based on samples of GIS applications.

(b) "Not-married pensioners" is defined as "persons who have never married, persons who are not now married because of death of spouse, divorce or legal separation, or persons whom the Minister has deemed to be not-married for purposes of the program."

(c) Excluding OAS in 1966 and OAS and GIS in 1967.

(d) Per pensioner having income.

(e) Of pensioners only.

(f) The years shown are those in which the incomes were actually received. Thus the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.

(g) Not eligible for either OAS or GIS at age 67 years in 1967.

(*) Less than five cases with the characteristics indicated were reported in the sample.

TABLE 26 - SOURCES AND AVERAGE AMOUNTS OF INCOME(a) FOR THE PREVIOUS YEAR, OF 1967 AND 1968 RECIPIENTS OF GIS, AND OF NON-PENSIONER SPOUSES OF 1968 RECIPIENTS, BY SEX AND MARITAL STATUS(b)

Source of income	Not-married pensioners(c)				Married pensioners				Non-pensioner spouses(d)	
	Male		Female		Male		Female		Female	Male
	1966(e)	1967(f)	1966(e)	1967(f)	1966(e)	1967(f)	1966(e)	1967(f)	1967(g)	1967(g)
1. Pensions, Annuities and Other Retirement Benefits										
Number(h)	7,965	6,995	12,010	12,120	27,060	25,565	1,435	1,815	(i)	(i)
Per cent of all with income(j)	7.0	6.4	10.4	10.2	23.9	23.2	1.2	1.5		
Average amount of income(k)	$380	$400	$341	$368	$745	$752	$407	$404		
2. Earnings from Employment										
Number(h)	3,960(L)	2,475	3,925(L)	2,260	13,655(L)	8,165	1,200(L)	980	4,220	955
Per cent of all with income(j)	3.5	2.2	3.4	1.9	12.1	7.4	1.0	0.8	3.8	0.8
Average amount of income(k)	$229	$245	$248	$236	$591	$549	$302	$349	$771	$938
3. Professional Fees Earned										
Number(h)	(L)	80*	(L)	140	(L)	280	(L)	60*	80*	0*
Per cent of all with income(j)		0.1*		0.1		0.3		0.1*	0.1*	0*
Average amount of income(k)		$70*		$150		$298		$355*	$346*	0*
4. Net Profits from Business										
Number(h)	(L)	1,085	(L)	1,205	(L)	5,365	(L)	500	1,020	485
Per cent of all with income(j)		1.0		0.9		4.6		0.4	0.9	0.4
Average amount of income(k)		$183		$196		$503		$235	$471	$798
5. Dividends										
Number(h)	4,650	3,120	9,470	11,495	6,660	7,010	3,085	3,015	1,070	145
Per cent of all with income(j)	4.1	2.8	8.2	9.6	5.9	6.4	2.7	2.5	1.0	0.1
Average amount of income(k)	$159	$186	$159	$163	$176	$198	$148	$151	$166	$112
6. Interest										
Number(h)	29,530	25,640	68,935	72,170	43,840	43,615	20,125	23,430	6,395	670
Per cent of all with income(j)	26.1	23.3	59.9	60.2	38.7	39.6	17.5	19.5	5.8	0.6
Average amount of income(k)	$181	$164	$183	$179	$226	$239	$146	$160	$191	$268

TABLE 26 - SOURCES AND AVERAGE AMOUNTS OF INCOME(a) FOR THE PREVIOUS YEAR, OF 1967 AND 1968 RECIPIENTS OF GIS, AND OF NON-PENSIONER SPOUSES OF 1968 RECIPIENTS, BY SEX AND MARITAL STATUS(b) (Concluded)

Source of income	Not-married pensioners(c)				Married pensioners				Non-pensioner spouses(d)	
	Male		Female		Male		Female		Female	Male
	1966(e)	1967(f)	1966(e)	1967(f)	1966(e)	1967(f)	1966(e)	1967(f)	1967(g)	1967(g)
7. Net Rent										
Number(h)	2,905	2,490	9,890	7,950	9,115	7,655	2,285	2,305	1,140	120
Per cent of all with income(j)	2.6	2.1	8.6	6.3	8.0	6.8	2.0	1.9	1.0	0.1
Average amount of income(k)	$238	$178	$267	$204	$351	$356	$308	$277	$328	$319
8. Other Net Income										
Number(h)	(L)	430	(L)	780	(L)	930	(L)	260	690	540
Per cent of all with income(j)		0.4		0.7		0.8		0.2	0.6	0.5
Average amount of income(k)		$167		$208		$283		$178	$453	$739
9. All Sources										
Number with income	38,545	36,455	90,625	91,985	74,705	73,600	24,390	27,920	12,275	2,315
Average amount of income(k)	$254	$245	$249	$239	$572	$564	$208	$220	$484	$830

(a) Exclusive of OAS and GIS.
(b) Based on samples of GIS applications.
(c) Defined as in Table 17, footnote (1).
(d) Not available for 1966.
(e) 1966 Income of GIS recipients in pay as of January 1967 (68 years of age and over).
(f) 1967 Income of GIS recipients in pay as of January 1968 (67 years of age and over).
(g) 1967 Income of spouses of GIS recipients in pay as of January 1968 (67 years of age and over).
(h) Since a person may have income from more than one source, there is duplication and the numbers having income from each source are not additive.
(i) Not available.
(j) That is, of all pensioners of same sex, married and not-married.
(k) From the specified source, for those with income from that source.
(L) For 1966, "Earnings from Employment" includes "Professional Fees Earned", "Net Profits from Business", and "Other Net Income".
(m) Corresponding figures for 1966 were $1,038 for male non-pensioner spouses and $500 for female non-pensioner spouses.
(*) Less than five cases with the characteristics indicated were reported in the sample.

TABLE 27 - PER CENT OF RECIPIENTS OF GIS AS OF JANUARY 1, 1967 AND 1968, HAVING NO INCOME(a) IN THE PREVIOUS YEAR, BY SEX, AGE, AND MARITAL STATUS(b)

Sex and age	Not-married pensioners(c)		Married pensioners in two-pensioner families		Married pensioners in one-pensioner families	
	1966(d)	1967(d)	1966(d)	1967(d)	1966(d)	1967(d)
Male						
67(e)	-	73.4	-	46.2	-	45.4
68	70.7	73.7	50.4	54.6	45.5	48.0
69	69.1	75.4	49.2	57.3	48.1	53.2
70 - 74	66.7	68.3	46.8	46.4	46.0	52.9
75 - 79	63.1	66.0	44.9	47.5	51.5	54.3
80 - 84	63.8	66.1	47.0	50.8	52.2	57.3
85 - 89	65.7	64.4	52.4	56.7	73.0	75.9
90 - 94	67.4	76.0	55.9	54.3	66.7*	45.5*
95 plus	75.4	71.7	75.0*	44.8*	0.0*	50.0*
All ages	65.4	68.0	46.9	49.1	47.9	52.2
Female						
67(e)	-	70.9	-	73.5	-	76.8
68	70.0	71.0	75.4	75.4	87.1	81.2*
69	66.8	68.0	76.3	78.6	91.9*	83.3
70 - 74	65.0	68.3	72.4	72.7	72.0	81.7
75 - 79	66.2	66.5	70.3	69.4	87.2*	69.2
80 - 84	65.9	66.8	70.8	70.3	100.0*	100.0*
85 - 89	67.1	69.3	72.2	67.9	100.0*	100.0*
90 - 94	72.8	70.7	79.5	78.9	- *	- *
95 plus	73.9	82.3	100.0	60.0*	100.0*	- *
All ages	66.4	68.1	72.3	72.2	81.5	79.5
Both sexes						
67(e)	-	71.7	-	67.8	-	50.1
68	70.2	71.8	70.8	70.4	51.4	50.3
69	67.4	70.1	69.1	72.5	52.6	56.1
70 - 74	65.4	68.3	61.3	61.7	47.9	54.5
75 - 79	65.3	66.3	55.6	56.5	53.1	54.9
80 - 84	65.3	66.6	54.7	57.5	52.7	58.0
85 - 89	66.7	67.8	57.7	60.0	73.3	76.7
90 - 94	71.2	72.3	63.0	59.5	66.7*	45.5*
95 plus	77.7	79.4	80.5*	51.0	50.0*	50.0*
All ages	66.1	68.0	59.2	60.6	50.5	54.2

(a) That is, no income except OAS in 1966 and OAS and GIS in 1967.
(b) Based on samples of GIS applications.
(c) Defined as in Table 17, footnote (1).
(d) The years shown are those in which the incomes were actually received. Thus the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.
(e) Not eligible for either OAS or GIS at age 67 years in 1967.

(*) Less than five cases with the characteristics indicated were reported in the sample.

TABLE 28 - PERCENTAGE DISTRIBUTIONS OF ALL GIS RECIPIENTS AND OF THOSE WITH INCOME, AND THEIR AVERAGE INCOMES, DURING THE PREVIOUS YEAR, AS OF JANUARY 1, 1967 AND 1968, BY SEX AND AGE(a)

Sex and Age	All GIS recipients		GIS recipients with income(b)		Average income during previous year(b)			
					Of all GIS recipients		Of GIS recipients with income	
	1967	1968	1966(c)	1967(c)	1966(c)	1967(c)	1966(c)	1967(c)
	%	%	%	%	$	$	$	$
Male								
67(d)	-	5.4	-	5.5	-	316	-	731
68	5.8	5.0	5.7	4.8	300	248	681	610
69	5.7	5.3	5.6	4.7	264	228	603	605
70 - 74	31.2	28.3	32.2	29.3	248	214	538	491
75 - 79	28.3	27.1	29.5	28.6	203	191	435	429
80 - 84	18.1	18.3	17.9	17.9	157	153	356	369
85 - 89	8.3	8.0	7.1	7.2	113	114	292	300
90 - 94	2.1	2.3	1.7	1.6	97	92	272	310
95 plus	0.5	0.4	0.3	0.4	78	74	302	229
All ages	100.0	100.0	100.0	100.0	207	193	464	458
Female								
67(d)	-	5.4	-	4.9	-	78	-	279
68	6.0	4.9	5.1	4.3	70	67	256	248
69	5.9	5.5	5.4	5.0	70	69	240	249
70 - 74	31.1	29.1	31.7	28.5	80	71	245	234
75 - 79	27.0	25.4	27.6	27.1	81	76	248	230
80 - 84	18.1	17.6	18.9	18.7	80	77	239	236
85 - 89	8.5	8.6	8.6	8.6	73	69	224	224
90 - 94	2.7	2.7	2.3	2.6	55	51	206	175
95 plus	0.6	0.7	0.4	0.4	37	34	178	184
All ages	100.0	100.0	100.0	100.0	78	72	242	234
Both sexes								
67(d)	-	5.4	-	5.2	-	174	-	510
68	5.9	4.9	5.4	4.5	162	141	478	432
69	5.8	5.4	5.5	4.8	148	131	423	415
70 - 74	31.2	28.8	32.0	28.9	150	127	392	359
75 - 79	27.5	26.1	28.6	27.8	133	124	344	328
80 - 84	18.1	17.9	18.4	18.3	112	108	295	298
85 - 89	8.4	8.4	7.9	8.0	89	86	255	257
90 - 94	2.5	2.5	2.0	2.1	70	66	234	224
95 plus	0.6	0.6	0.4	0.4	52	46	230	204
All ages	100.0	100.0	100.0	100.0	131	121	352	342

(a) Based on samples of GIS applications.
(b) Excluding OAS in 1966 and OAS and GIS in 1967.
(c) The years shown in these columns are those in which the incomes were actually received. Thus, the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.
(d) Not eligible for either OAS or GIS at age 67 years in 1967.

TABLE 29 - OAS PENSIONERS BY GIS STATUS, NUMBERS AND PERCENTAGES, BY PROVINCE, MAY 1970, AND FOR CANADA, MAY 1967 TO 1970

Province	Number of OAS pensioners				Percentage of OAS pensioners			
	Total	Without GIS	With partial GIS	With full GIS	Total	Without GIS	With partial GIS	With full GIS
Newfoundland	31,707	6,855	5,601	19,251	100.0	21.6	17.7	60.7
Prince Edward Island	12,234	3,763	3,037	5,434	100.0	30.8	24.8	44.4
Nova Scotia	70,526	28,707	15,623	26,196	100.0	40.7	22.2	37.1
New Brunswick	53,302	21,364	10,641	21,297	100.0	40.1	20.0	39.9
Quebec	398,087	173,950	74,589	149,548	100.0	43.7	18.7	37.6
Ontario	619,045	370,937	124,910	123,198	100.0	59.9	20.2	19.9
Manitoba	94,214	46,368	21,919	25,927	100.0	49.2	23.3	27.5
Saskatchewan	92,827	48,242	19,159	25,426	100.0	52.0	20.6	27.4
Alberta	114,387	57,165	24,469	32,753	100.0	50.0	21.4	28.6
British Columbia	196,249	111,166	38,850	46,233	100.0	56.6	19.8	23.6
Northwest Territories	797	142	72	583	100.0	17.8	9.0	73.2
Yukon Territory	462	218	34	210	100.0	47.2	7.4	45.4
Canada 1970	1,683,837	868,877	338,904	476,056	100.0	51.6	20.1	28.3
1969	1,513,284	736,546	302,507	474,231	100.0	48.7	20.0	31.3
1968	1,365,453	629,435	298,930	437,088	100.0	46.1	21.9	32.0
1967	1,239,385	561,827	260,183	417,375	100.0	45.3	21.0	33.7

a resident of the country for one year, or whose father or mother has been domiciled in Canada from a date three years immediately prior to the date of birth of the child. Payment is made by cheque each month, normally to the mother, although any person who substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under 10 years of age and $8 for each child aged 10 or over but under 16 years. If the allowances are not spent for the purposes outlined in the Act, payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school-attendance legislation, who ceases to be maintained by a parent, who ceases to be a resident of Canada, or on behalf of a girl who is married and under age 16.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. The Regional Director located at Edmonton also administers the accounts of residents in the Yukon and Northwest Territories. Table 30 gives statistics for each province for recent years.

The federal government pays family assistance, at the rates applicable for family allowances, for each child under 16 years of age resident in Canada and supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returned to Canada to reside permanently. The assistance, which is payable monthly for the first year of the child's residence in Canada, is intended to bridge the gap until the child becomes eligible for family allowances. The eligibility requirements, other than that relating to residence, are the same for family assistance as for family allowances.

The province of Quebec introduced its own family allowances program, supplementing the federal scheme, under legislation enacted in 1967 and Newfoundland in 1966 introduced a program called the Parents' Supplement (Schooling Allowances), under which payments are made for children attending school. (See p.120).

Subsection 4 - Youth Allowances

Legislation providing for a program of youth allowances became effective September 1, 1964. The federal government does not provide youth allowances in Quebec, which has had

TABLE 30 - FAMILY ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1970

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance (a)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Newfoundland.....1965	68,418	210,016	3.07	20.59	6.71	16,871,056
1966	69,346	210,512	3.04	20.40	6.71	16,945,059
1967	70,435	210,082	2.98	20.08	6.73	16,960,053
1968	72,041	210,812	2.93	19.70	6.73	16,983,302
1969	73,786	210,938	2.86	19.27	6.76	17,046,934
1970	74,922	209,866	2.80	18.89	6.75	17,048,134
Prince Edward Island....1965	14,191	40,201	2.83	19.12	6.75	3,266,459
1966	14,054	39,632	2.82	19.03	6.75	3,231,716
1967	14,099	39,342	2.79	18.81	6.74	3,190,484
1968	14,236	39,100	2.75	18.60	6.77	3,178,692
1969	14,312	38,684	2.70	18.32	6.79	3,159,590
1970	14,328	37,966	2.65	18.03	6.80	3,120,546
Nova Scotia.....1965	105,163	269,845	2.57	17.24	6.72	21,776,091
1966	104,856	267,689	2.55	17.18	6.74	21,636,528
1967	105,214	264,998	2.52	17.01	6.75	21,507,992
1968	106,712	263,340	2.47	16.73	6.78	21,410,766
1969	107,741	261,086	2.42	16.43	6.79	21,307,047
1970	108,451	257,330	2.37	16.16	6.82	21,145,467
New Brunswick.....1965	82,578	235,714	2.85	19.24	6.74	19,069,036
1966	82,851	233,724	2.82	19.05	6.76	18,982,908
1967	82,929	229,798	2.77	18.76	6.77	18,752,034
1968	84,108	227,747	2.71	18.37	6.79	18,595,852
1969	85,840	224,085	2.61	17.76	6.80	18,399,405
1970	86,141	218,999	2.54	17.34	6.83	18,070,949
Quebec.....1965	780,305	2,037,605	2.61	17.60	6.74	163,888,091
1966	792,955	2,043,428	2.57	17.38	6.76	164,972,052
1967	805,315	2,034,966	2.53	17.10	6.77	165,095,827
1968	818,220	2,025,173	2.48	16.78	6.78	164,637,234
1969	829,169	1,998,409	2.41	16.40	6.80	163,502,053
1970	837,683	1,963,792	2.34	16.01	6.84	161,788,099
Ontario.....1965	964,468	2,248,642	2.33	15.65	6.71	179,056,316
1966	983,502	2,284,059	2.32	15.61	6.73	182,377,587
1967	1,007,038	2,308,919	2.29	15.48	6.75	185,309,485
1968	1,029,734	2,329,769	2.26	15.30	6.76	187,635,949
1969	1,048,475	2,337,972	2.23	15.13	6.78	189,231,474
1970	1,065,683	2,363,271	2.22	14.98	6.75	190,401,103

(a) Based on gross payment for March.

TABLE 30 - FAMILY ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1970 (Concluded)

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(a)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Manitoba.....1965	133,500	323,862	2.43	16.24	6.69	25,926,570
1966	132,148	321,747	2.43	16.30	6.71	25,925,991
1967	131,011	315,166	2.41	16.26	6.76	25,651,443
1968	131,098	312,777	2.39	16.12	6.76	25,432,808
1969	132,233	311,607	2.36	15.96	6.76	25,331,933
1970	132,530	307,626	2.32	15.78	6.80	25,165,427
Saskatchewan.....1965	131,449	335,381	2.55	17.09	6.70	26,891,288
1966	131,266	332,952	2.54	17.11	6.74	26,988,369
1967	130,876	330,015	2.52	17.05	6.76	26,870,934
1968	131,164	326,957	2.49	16.90	6.78	26,710,541
1969	130,999	321,791	2.46	16.72	6.80	26,470,525
1970	128,328	312,003	2.43	16.58	6.82	25,937,454
Alberta.....1965	212,630	525,976	2.47	16.57	6.70	41,996,327
1966	213,489	525,859	2.46	16.58	6.74	42,345,742
1967	216,086	527,411	2.44	16.50	6.76	42,563,978
1968	220,778	531,409	2.41	16.35	6.79	42,990,910
1969	226,628	535,468	2.36	16.12	6.83	43,554,268
1970	231,903	539,975	2.33	15.90	6.82	44,001,049
British Columbia.....1965	247,635	573,714	2.32	15.58	6.73	45,745,199
1966	254,871	589,041	2.31	15.60	6.75	47,006,572
1967	264,480	605,443	2.29	15.50	6.77	48,525,782
1968	273,093	616,519	2.26	15.34	6.80	49,773,623
1969	280,671	624,487	2.22	15.20	6.85	50,686,069
1970	289,747	634,712	2.19	15.01	6.85	51,646,363
Yukon and Northwest Territories.....1965	6,212	16,057	2.58	17.19	6.65	1,288,798
1966	6,298	16,414	2.61	17.21	6.60	1,322,300
1967	6,458	16,734	2.59	17.84	6.88	1,366,935
1968	6,917	17,883	2.59	17.71	6.85	1,424,781
1969	7,230	18,373	2.54	17.57	6.92	1,496,764
1970	7,840	19,762	2.52	17.26	6.85	1,585,909
Canada.....1965	2,746,549	6,817,013	2.48	16.68	6.72	545,775,231
1966	2,785,636	6,865,057	2.46	16.59	6.74	551,734,824
1967	2,833,941	6,882,874	2.43	16.42	6.76	555,794,947
1968	2,888,101	6,901,486	2.39	16.19	6.77	558,774,458
1969	2,937,084	6,882,900	2.39	15.93	6.81	560,186,052
1970	2,977,556	6,865,302	2.31	15.68	6.79	559,910,500

(a) Based on gross payment for March.

its own program, called schooling allowances, since 1961. With the introduction of the federal scheme, Quebec agreed to make certain changes in its schooling allowances program so that it would be comparable to the federal measure; since then that province has been compensated by a tax abatement adjusted to equal the amount that the federal government would otherwise have paid in allowances to Quebec residents. The federal youth allowances and the Quebec schooling allowances programs cover all eligible young people in Canada.

Under the federal program, monthly allowances of $10 are payable in respect of all dependent children aged 16 and 17 who are receiving full-time educational training or are precluded from doing so by reason of physical or mental infirmity. Both the parent or guardian and the child must normally be physically present and living in a province other than Quebec. The allowance is not payable to a parent who resides in Quebec or outside Canada, regardless of where his child may be attending school. However, a child may attend school in Quebec or outside Canada or, if disabled, receive care or training in Quebec or outside Canada, and still be considered eligible, on the basis that he is a resident of a province other than Quebec but is temporarily absent.

Allowances normally commence with the month following that in which family allowances cease and continue until the school year terminates. They are paid retroactively for the summer months when the child returns to school at the commencement of the new school year, although allowances for a disabled child not attending school are payable continuously throughout the year. Should a student leave school, leave the country permanently, cease to be maintained, take up residence in Quebec, or die, the allowance will cease. Otherwise, the youth allowance continues until the end of the month in which the young person reaches age 18. Youth allowances are considered not to be income for any purpose of the Income Tax Act.

The program is administered by the Department of National Health and Welfare. The national director of the family allowances and old age security programs is also responsible for administering youth allowances, assisted by regional directors located in each of the provincial capitals other than Quebec City. The costs of youth allowances are met from the Consolidated Revenue Fund. Table 31 contains some statistics.

TABLE 31 - YOUTH ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1966 TO 1970

Province and year	Youths for whom allowance paid in March			Net total allowance paid during fiscal year
	Attending school full-time	Having physical or mental infirmity	Total youths	
	No.	No.	No.	$
Newfoundland.....1966	14,970	151	15,121	1,591,901
1967	15,527	157	15,684	1,686,661
1968	15,867	157	16,024	1,747,142
1969	17,047	159	17,206	1,865,324
1970	17,886	160	18,046	1,967,468
Prince Edward Island.....1966	3,553	40	3,593	395,465
1967	3,432	38	3,470	397,505
1968	3,347	33	3,380	392,096
1969	3,516	27	3,543	401,466
1970	3,750	15	3,765	422,204
Nova Scotia.....1966	22,972	176	23,148	2,691,768
1967	22,938	192	23,130	2,654,786
1968	23,518	155	23,673	2,697,524
1969	24,871	154	25,025	2,833,634
1970	26,467	117	26,584	3,002,805
New Brunswick.....1966	19,868	204	20,072	2,311,244
1967	19,878	199	20,077	2,300,043
1968	20,689	151	20,840	2,361,241
1969	21,552	107	21,659	2,486,409
1970	22,260	108	22,368	2,561,437
Ontario.....1966	189,923	783	190,706	21,978,399
1967	192,861	1,234	194,095	22,491,673
1968	207,176	1,399	208,575	23,763,161
1969	221,206	1,370	225,576	25,343,412
1970	232,114	1,157	233,271	26,653,435
Manitoba.....1966	27,930	148	28,078	3,249,490
1967	27,775	134	27,909	3,242,828
1968	28,708	125	28,833	3,293,702
1969	30,262	69	30,331	3,475,233
1970	31,423	61	31,484	3,601,849
Saskatchewan.....1966	29,605	94	29,699	3,414,834
1967	29,718	86	29,804	3,434,721
1968	30,424	86	30,510	3,487,264
1969	32,082	73	32,155	3,633,295
1970	33,258	89	33,347	3,783,018
Alberta.....1966	41,877	181	42,058	4,836,771
1967	42,868	235	43,103	4,960,783
1968	44,934	195	45,129	5,148,230
1969	48,478	185	48,663	5,498,398
1970	51,069	195	51,264	5,823,362
British Columbia.....1966	51,556	214	51,770	5,934,292
1967	54,039	252	54,291	6,159,249
1968	56,731	208	56,939	6,462,040
1969	60,318	184	60,502	6,836,640
1970	63,381	173	63,554	7,195,255
Yukon.....1966	258	1	259	30,210
1967	243	1	244	28,044
1968	280	-	280	29,340
1969	296	-	296	33,534
1970	313	1	314	39,394
Northwest Territories.....1966	290	-	290	34,176
1967	312	2	314	39,340
1968	377	5	382	45,240
1969	427	2	429	49,928
1970	479	-	479	51,672
Total.....1966	402,802	1,992	404,794	46,468,550
1967	409,591	2,530	412,121	47,395,633
1968	432,051	2,514	434,565	49,426,980
1969	460,055	2,330	462,385	52,457,272
1970	482,400	2,076	484,476	55,101,899

Section 2 - Federal-Provincial Welfare Programs

Subsection 1 - Canada Assistance Plan

The Canada Assistance Plan was enacted in 1966 as a comprehensive public assistance measure to complement other income security measures. It provides, under agreements with the provinces, for federal contributions of 50 per cent of the costs of assistance to persons in need and of the costs of certain welfare services. The plan has largely replaced the Unemployment Assistance Act, 1956, although the latter continues in effect in some provinces for an interim period with respect to certain programs that utilize a means test and are being phased out but that are not covered under the Canada Assistance Plan. All provinces had signed agreements under the Canada Assistance Plan by the end of August 1967 and the Yukon signed in December 1969. The arrangements for contracting out of certain shared-cost programs that were introduced in 1965 under the Established Programs (Interim Arrangements) Act are applied to Quebec's agreement. It is provided that the provinces may discontinue their programs of old age assistance, blind persons allowances, and disabled persons allowances and provide instead aid under their general programs, with costs shared under the plan. (see pp. 96-103).

The plan extends federal sharing to include the following costs, which were not shared under the Unemployment Assistance Act: assistance to needy mothers with dependent children, maintenance of children in the care of provincially approved child welfare agencies, health care services to needy persons, and the extension of welfare services to prevent or remove causes of dependency or to assist recipients in achieving self-support.

Health care services may include medical, surgical, obstetrical, optical, dental, and nursing services; drugs; dressings; prosthetic appliances; and other items associated with the provision of such services. Welfare services may include rehabilitation services; casework; counselling and assessment services; adoption services; and homemaker, day-care, and similar services supplied to persons in need or to persons to whom the service is essential if they are to remain self-supporting.

The only eligibility requirement specified is that of need, which is determined through an assessment of budgetary

requirements as well as of income and resources. A province must not require previous residence as a condition of eligibility for assistance or for continued assistance; rates of assistance and eligibility requirements are set by the province so that they may be adjusted to local conditions and the needs of special groups; and the provinces must establish procedures for appeal from decisions that relate to the provision of assistance.

The federal government reimburses the provinces for 50 per cent of the cost of assistance provided to persons in need and for 50 per cent of certain costs of improving or extending welfare services.

"Assistance" includes any form of aid to or on behalf of persons in need for the purpose of providing basic requirements such as food, shelter, and clothing; items necessary for the safety, well-being, or rehabilitation of a person in need, or for a handicapped person, such as special food or clothing, telephone, or rehabilitation allowance; maintenance in a home for special care such as a home for the aged, a nursing home, or a welfare institution for children; travel and transportation; funerals and burials; health care services; welfare services purchased by or at the request of provincially approved agencies; and comfort allowances for inmates of institutions.

The cost of improving and extending welfare services may be calculated either (1) as the amount by which the cost of providing welfare services exceeds that of the period from April 1, 1964 to March 31, 1965 or (2) as the cost of employing persons who are engaged wholly or mainly in the performance of welfare service functions and who are employed in positions filled after March 31, 1965. No province has followed the second alternative. Included for sharable purposes are the costs of salaries and employee benefits, travel, research, consultation, fees for conferences and seminars, and certain costs of staff training. The sharing of cost of work activity projects that prepare persons for employment and of the extension of provincial welfare services to Indians on reserves, on Crown lands, or in unorganized territory, is governed by special agreements.

Federal payments under the Canada Assistance Plan amounted to $225.6 million in the fiscal year 1967-68 and to $256.8 million in 1968-69 (see Table 32).

As noted above, all programs under which aid is based on a needs test are included for reimbursement under the Canada Assistance Plan under which all provinces and the Yukon have signed agreements.

The Unemployment Assistance Act remains in effect in the Northwest Territories and, for a transitional period, in some provinces to cover certain means-test programs during the process of conversion to needs-test programs.

Under the Unemployment Assistance Act the federal government was authorized to enter into an agreement with any province to reimburse it for 50 per cent of the unemployment assistance expenditures made by the province and its municipalities to persons and their dependents who are unemployed and in need. Payments to both employable and unemployable persons are sharable, as are the costs of maintaining persons in homes for special care, such as nursing homes and homes for the aged, and the costs of supplementary aid to recipients of old age security pensions, old age assistance, blind persons' allowances, disabled persons' allowances, and unemployment insurance benefits where the amount of assistance is determined on the basis of need. Federal sharing was extended to mothers' allowances from April 1, 1966.

During the year ended March 31, 1968, the federal government made payments amounting to $26 million for unemployment assistance. Federal payments were reduced to $16.7 million in 1968-69 and to $14.6 million in 1969-70. These amounts include payments to Quebec by the Department of Finance under the Established Programs (Interim Arrangements) Act.

Subsection 2 - Old Age Assistance

The Old Age Assistance Act of 1951, as amended, provided in 1969 for federal reimbursement to the provinces for assistance to persons age 65 or over who meet the ten years' residence and income requirements. For an unmarried person, total income allowed, including assistance, could not exceed $1,260 a year. For a married couple, it could not exceed $2,220 a year or, when the spouse was blind within the meaning of the Blind Persons' Act, $2,580 a year. Table 33 sets out some statistics of Old Age Assistance in recent years.

A recipient was transferred to Old Age Security on reaching the eligible age for it, which in 1969 was 66 years (see p. 69). The federal contribution was 50 per cent of $75 a month or of the assistance paid, whichever was less. The province

TABLE 32 - FEDERAL PAYMENTS UNDER THE CANADA ASSISTANCE PLAN, (a) BY PROVINCE, FISCAL YEARS 1967-68, 1968-69 and 1969-70

Province	1967-68	1968-69	1969-70
	$	$	$
Newfoundland	17,901,873	21,061,808	20,288,580
Prince Edward Island	1,738,858	2,549,257	3,292,523
Nova Scotia	10,263,995	11,022,716	15,245,837
New Brunswick	7,185,018	9,905,988	11,795,292
Quebec	(b)	(b)	(b)
Ontario	100,287,774	118,303,660	131,838,661
Manitoba	15,571,938	13,981,779	19,260,412
Saskatchewan	13,403,926	14,129,601	17,233,414
Alberta	26,538,313	28,634,906	31,334,876
British Columbia	32,719,792	37,215,888	43,086,262
Yukon	-	-	152,889(c)
Total	225,611,487	256,805,603	293,528,746

(a) Includes costs of public assistance payments, child welfare maintenance, health care, and extensions and improvements in welfare services. Includes payments made for claims received during the fiscal year for expenditures made in the previous fiscal year.

(b) Payments to Quebec are made by the Department of Finance under the terms of the Established Programs (Interim Arrangements) Act. Payments in 1967-68, 1968-69, and 1969-70 amounted to $117 million, $149.3 million, and $156.6 million respectively.

(c) Partial year only.

TABLE 33 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969

Province and year	Recipients in March	Average amount of monthly assistance	Federal government contribution during year
	No.	$	$
Newfoundland.....1965	5,088	72.41	2,220,908
1966	4,080	72.14	2,121,068
1967	3,110	71.69	1,675,756
1968	844	66.24	985,356
1969	-	-	189,183
Prince Edward Island...1965	1,229	70.43	508,587
1966	988	70.73	498,378
1967	712	70.35	390,463
1968	206	70.60	205,734
1969	-	-	18,308
Nova Scotia.....1965	5,574	68.53	2,302,860
1966	4,423	67.96	2,188,257
1967	3,134	68.39	1,667,068
1968	1,879	66.20	1,089,056
1969	786	65.71	612,926
New Brunswick.....1965	5,356	70.28	2,303,178
1966	4,200	69.72	2,161,779
1967	3,033	70.06	1,620,148
1968	1,957	71.27	1,139,781
1969	822	69.36	682,834
Quebec.....1965	39,239	70.35	16,589,045
1966	31,971	70.07	15,941,412(a)
1967	22,817	70.40	12,291,269(a)
1968	12,839	69.72	8,401,864(a)
1969	2,871	69.78	3,627,851(a)
Ontario.....1965	26,049	67.03	10,465,257
1966	19,991	67.28	10,006,001
1967	13,279	67.04	7,238,584
1968	1,340	59.47	1,366,432
1969	4	52.86	141,678

(a) Effective April 1, 1965, Quebec received compensation under the terms of Established Programs (Interim Arrangements) Act. Figures are shown for the federal share in the amounts that would have been paid to Quebec if payments had continued under the original agreements.

TABLE 33 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969 (Concluded)

Province and year	Recipients in March	Average amount of monthly assistance	Federal government contribution during year
	No.	$	$
Manitoba.....1965	5,520	69.15	2,329,362
1966	4,241	69.02	2,188,141
1967	2,956	68.73	1,611,858
1968	1,647	67.49	1,038,975
1969	658	67.50	544,640
Saskatchewan.....1965	5,463	69.04	2,294,105
1966	3,975	68.87	2,097,642
1967	1,496	67.62	1,131,452
1968	39	58.53	295,865
1969	-	-	19,416(CR.)
Alberta.....1965	6,810	69.00	2,901,039
1966	6,453	68.61	2,795,633
1967	3,617	65.62	2,092,389
1968	1,710	66.08	1,256,491
1969	13	66.43	375,906
British Columbia.....1965	6,829	71.82	2,991,013
1966	5,478	71.74	2,836,336
1967	4,074	72.18	2,252,115
1968	2,377	70.54	1,520,674
1969	949	71.21	844,273
Yukon.....1965	31	75.00	13,880
1966	26	75.00	13,553
1967	15	74.73	8,826
1968	9	75.00	5,725
1969	4	75.00	3,313
Northwest Territories...1965	166	74.32	71,721
1966	133	73.64	73,722
1967	120	72.75	62,085
1968	75	73.09	46,418
1969	40	73.21	30,536
Canada.....1965	107,354	69.43	44,990,955
1966	84,959	69.31	42,921,922(b)
1967	58,363	69.25	32,042,013(b)
1968	24,922	68.41	17,352,371(b)
1969	6,147	69.20	7,052,033

(b) Figures include the federal share which would have been paid to Quebec if payments had continued under the original agreements (see footnote (a) above).

administered the program and, within the limits of the federal Act, fixed the amount of assistance payable, the maximum income allowed, and other conditions of eligibility. Effective April 1, 1965, compensation was made to Quebec under the Established Programs (Interim Arrangements) Act.

Effective January 1, 1970, the old age assistance program disappeared when the qualifying age for old age security pensions had been lowered to 65 years.

Subsection 3 - Allowances for Blind Persons

The Blind Persons Act of 1951, as amended, provides for federal reimbursement to the provinces for allowances to blind persons age 18 or over who meet the ten-years'-residence and income requirements. For an unmarried person, total income including the allowance may not exceed $1,500 a year; for a person with no spouse but with one or more dependent children, $1,980; for a married couple, $2,580. When the spouse is also blind, income of the couple may not exceed $2,700. Blindness Allowance statistics appear in Table 34.

The federal contribution may not exceed 75 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed. Effective April 1, 1965, compensation was made to Quebec under the Established Programs (Interim Arrangements) Act.

Under the terms of the Canada Assistance Plan a province may elect to aid needy blind persons under the general assistance program with costs shared under the Canada Assistance Plan (see p. 94). In accordance with this provision several provinces no longer accept applications under the Blind Persons Allowance Act. They may also transfer current recipients of blind persons allowances to their general programs, provided that there is no decrease in benefits. By mid-1970 three provinces (Ontario, Saskatchewan, and Alberta) had discontinued receipt of applications under this program.

TABLE 34 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969

Province and year	Recipients in March	Average amount of monthly allowance	Federal government contribution during year
	No.	$	$
Newfoundland.....1965	460	73.49	300,474
1966	445	73.27	304,203
1967	438	72.98	292,224
1968	417	73.18	285,162
1969	401	73.30	277,298
Prince Edward Island....1965	71	73.47	51,020
1966	72	72.92	47,372
1967	67	72.92	46,142
1968	69	73.72	45,639
1969	63	73.27	40,337
Nova Scotia.....1965	750	73.41	509,671
1966	714	72.72	487,504
1967	682	73.19	466,060
1968	636	73.28	440,422
1969	577	73.50	405,049
New Brunswick.....1965	679	74.10	456,965
1966	626	73.35	438,437
1967	589	73.44	407,930
1968	536	73.52	371,888
1969	491	73.99	345,044
Quebec.....1965	2,843	73.47	1,892,813
1966	2,712	73.28	1,840,998(a)
1967	2,560	73.17	1,714,789(a)
1968	2,424	73.42	1,631,232(a)
1969	2,242	73.53	1,532,632(a)
Ontario.....1965	1,906	67.93	1,179,138
1966	1,820	67.54	1,153,040
1967	1,710	67.09	1,081,629
1968	435	54.27	259,748
1969	330	51.52	178,717

(a) Effective April 1, 1965, Quebec received compensation under the terms of the Established Programs (Interim Arrangements) Act. Figures are shown for comparative purposes only and represent the federal share, which would have been paid to Quebec if payments had continued under the original agreements.

TABLE 34 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969 (Concluded)

Province and year	Recipients in March	Average amount of monthly allowance	Federal government contribution during year
	No.	$	$
Manitoba.....1965	401	72.66	258,946
1966	364	72.19	251,385
1967	325	72.58	226,219
1968	294	71.91	200,718
1969	276	71.99	186,795
Saskatchewan.....1965	391	72.02	256,063
1966	366	71.74	248,004
1967	272	71.60	204,547
1968	131	68.86	110,352
1969	99	65.85	67,091
Alberta.....1965	475	72.36	311,992
1966	448	72.38	307,676
1967	412	71.89	284,078
1968	376	73.02	258,007
1969	315	73.55	229,294
British Columbia.....1965	556	73.15	372,208
1966	532	73.30	358,287
1967	484	73.60	336,639
1968	451	73.81	315,769
1969	439	73.50	300,888
Yukon.....1965	5	75.00	2,666
1966	6	75.00	3,994
1967	5	75.00	3,881
1968	6	75.00	3,460
1969	4	75.00	3,518
Northwest Territories...1965	49	74.39	32,746
1966	44	75.00	32,310
1967	38	75.00	28,069
1968	33	74.24	23,083
1969	30	75.00	22,969
Canada.....1965	8,586	72.10	5,624,702
1966	8,149	71.80	5,473,190(b)
1967	7,582	71.70	5,092,207(b)
1968	5,808	71.19	3,945,481(b)
1969	5,267	71.95	3,589,632(b)

(b) Figures include the federal share which would have been paid to Quebec if payments had continued under the original agreements.

Subsection 4 - Allowances for Disabled Persons

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons age 18 or over who meet the required definition of "permanent and total disability", the ten-years'-residence requirement, and specified income limits. For an unmarried person, total income including the allowance may not exceed $1,260 a year. For a married couple the limit is $2,220 a year except that, if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $2,580 a year. Statistics for recent years are set out in Table 35.

The federal contribution may not exceed 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed and other conditions of eligibility. Effective April 1, 1965, compensation was made to Quebec under the Established Programs (Interim Arrangements) Act.

Under the terms of the Canada Assistance Plan a province may elect to aid needy disabled persons under the general assistance program with costs shared under the Canada Assistance Plan (see p. 94). In accordance with this provision several provinces no longer accept applications under the Disabled Persons Act. They may also transfer current recipients of disabled persons allowances to their general programs, provided that there is no decrease in benefits. By mid-1970, six provinces (Newfoundland, Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, and Alberta) had discontinued acceptance of applications under this program.

Subsection 5 - Fitness and Amateur Sport

The Fitness and Amateur Sport Program is designed to increase the number of participants at all levels of competitive and non-competitive physical recreation and amateur sport activity from the day camp to the Canada Games to the Olympic Games; to help provide the participants with the skills, the means and the opportunity to benefit from recreation; and to help make available to all citizens the facilities and leadership to participate freely in the recreational activities of their choice. These objectives are predicated on the assumption

TABLE 35 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969

Province and year	Recipients in March	Average amount of monthly allowance	Federal government contribution during year
	No.	$	$
Newfoundland.....1965	1,746	74.63	750,279
1966	1,817	74.49	804,197
1967	1,873	74.55	833,340
1968	1,393	74.43	465,500
1969	82	63.04	461,943
Prince Edward Island....1965	797	74.31	360,150
1966	788	74.25	349,881
1967	814	74.35	368,992
1968	78	72.08	176,869
1969	54	71.62	18,749
Nova Scotia.....1965	3,329	73.88	1,446,725
1966	3,474	73.92	1,524,103
1967	3,522	73.88	1,584,061
1968	3,482	73.53	1,564,079
1969	3,371	73.53	1,535,758
New Brunswick.....1965	2,263	74.36	987,471
1966	2,320	74.34	1,030,637
1967	2,266	74.36	1,041,900
1968	2,265	74.33	1,015,796
1969	2,292	74.37	1,022,271
Quebec.....1965	20,171	74.23	9,090,736
1966	19,603	74.20	8,821,586(a)
1967	19,273	74.15	8,535,524(a)
1968	18,649	74.13	8,292,666(a)
1969	12,506	74.15	7,952,096(a)
Ontario.....1965	17,222	73.23	7,378,219
1966	18,406	73.10	7,823,576
1967	19,800	72.02	8,377,469
1968	2,401	64.97	1,096,998
1969	1,436	63.02	685,643

(a) Effective April 1, 1965, Quebec received compensation under the terms of the Established Programs (Interim Arrangements) Act. Figures are shown for comparative purposes only and represent the federal share which would have been paid to Quebec if payments had continued under the original agreements.

TABLE 35 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1969 (Concluded)

Province and year	Recipients in March	Average amount of monthly allowance	Federal government contribution during year
	No.	$	$
Manitoba.....1965	1,538	73.96	679,916
1966	1,566	73.80	688,650
1967	1,547	73.91	687,543
1968	1,498	73.64	671,508
1969	1,428	73.56	646,169
Saskatchewan.....1965	1,780	74.18	784,700
1966	1,871	74.08	824,777
1967	390	70.94	189,817
1968	272	69.01	129,610
1969	170	68.71	80,794
Alberta.....1965	1,874	73.56	830,170
1966	1,933	73.18	851,833
1967	1,931	72.89	859,166
1968	1,925	72.75	844,821
1969	1,810	73.14	821,572
British Columbia.....1965	2,336	73.94	1,037,484
1966	2,385	73.86	1,061,500
1967	2,422	73.75	1,071,978
1968	2,445	73.59	1,086,330
1969	2,480	73.68	1,099,806
Yukon.....1965	2	75.00	1,148
1966	2	75.00	900
1967	2	75.00	900
1968	3	75.00	1,350
1969	3	75.00	1,350
Northwest Territories...1965	45	75.00	18,435
1966	26	74.47	19,376
1967	23	74.62	11,212
1968	27	73.10	11,097
1969	31	74.27	14,396
Canada.....1965	53,103	73.86	23,365,493
1966	54,191	73.76	23,801,016(b)
1967	53,863	73.57	23,561,903(b)
1968	34,438	73.28	15,356,624(b)
1969	30,663	73.39	14,340,547(b)

(b) Figures include the federal share which would have been paid to Quebec if payments had continued under the original agreements (see footnote (a) above).

that every Canadian should develop a level of fitness sufficient to contribute positively to his physical and mental health and that Canadian athletes should develop a level of performance in national and international competitions which will contribute to national unity and international prestige.

Under the Fitness and Amateur Sport Act, 1961, up to five million dollars may be provided to encourage, promote and develop fitness and amateur sport in Canada. The Act also provides for the National Advisory Council on Fitness and Amateur Sport to consider any pertinent questions and advise the Minister as it sees fit. Council consists of not more than 30 members appointed by the Governor in Council, at least one member being appointed from each province.

As a result of progress made under the program since its inception in 1961, the needs have evolved and the program is being reoriented in order to more effectively approach its objectives.

Following the report of the Task Force on Sports for Canadians, the Montmorency Conference on Leisure, recommendations from the National Advisory Council, and the conclusions of an internal study, the Minister proposed in March 1970 a new sports policy for Canadians. Advocating the benefits of mass participation and the inculcation of sports and recreation into the Canadian culture, the policy aims primarily at reinforcing and increasing the administrative strength of Canadian sports and recreation agencies, by providing them with administrative, financial, and other professional assistance. The Department provides grants for specific projects and operates some of its own, all to facilitate the development of resources and motivate participation by all Canadians.

The federal program for Fitness and Amateur Sport for 1970-71 concentrates on the following:

(a) grants and support to national fitness and sport organizations to improve the standards of administration, coaching, and instruction, to increase participation in physical recreation, and to provide aid to the holding of competitions ($2,000,000);

(b) promotion and support of special projects including the Arctic Games, the Canada Games, the Canada Fitness Awards, and assistance in the holding of sports events of nationwide interest ($1,400,000);

(c) planning, training, research, and communications in support of increased participation in physical recreation by all Canadians;

(d) grants to provinces ($500,000). The cost-sharing agreements with the provinces for fitness and amateur sport programs terminated with the 1969-70 fiscal year, but this $500,000 has been allocated to provide for the phase-out period while new programs are being developed on a joint-project basis.

Subsection 6 - National Welfare Grants

The National Welfare Grants program was established in 1962 to help develop and strengthen welfare services in Canada through a general welfare and professional training grant and a welfare research grant. The variety of provisions within the program, along with its associated consultative services, allow it to operate as a flexible instrument in the development of welfare services and to give a major emphasis to experimental activities in the welfare field.

The allotment for the year ended March 31, 1970, was $2,500,000. Provincial governments, municipal welfare departments, non-governmental welfare agencies, and citizens groups, universities, and individuals may be the ultimate recipients of project grants under one or more provisions of the program. Most are financed and administered entirely by the federal government; others require application through a provincial department of welfare that actually administers the award on a shared-cost basis.

General welfare, bursary, training, and staff development grants are available to provinces on a shared-cost basis for projects designed to improve welfare administration and to develop provincial consultative and co-ordinating services; for bursaries for full-time graduate training at Canadian schools of social work; and for staff training and development grants for employees of government and voluntary welfare agencies where the costs are not sharable under the Canada Assistance Plan.

The other provisions of the program are administered by the federal government. Welfare scholarships are awarded for graduate study in Canadian schools of social work and fellowships for advanced study in Canadian and foreign

universities. Teaching and field-instruction grants assist with the development of new Canadian schools of social work, and with certain operating costs at existing schools. Demonstration grants assist established agencies or newly emerging citizens' organizations with a wide variety of projects designed to modify existing services and to experiment with new approaches to the solution of social problems.

Under the welfare research grant, funds are provided for research projects undertaken by public and voluntary welfare and correctional agencies, universities, and research institutions. Grants are available to national voluntary welfare agencies to assist with projects not eligible for support under other provisions of the program. Particular emphasis is given to projects designed to foster planning and co-ordination.

Effective April 1, 1967, a mental retardation grant was established for a five-year period and is being administered in conjunction with the National Welfare Grant Program. It supports research and demonstration projects designed to expand knowledge and to apply that knowledge to the provision of services and to preventive programs in that field.

Expenditures under the National Welfare Grant Program for the year ended March 31, 1970 totalled $1,924,541 and under the Mental Retardation Grant $288,171. Of the former, $334,671 was expended on research projects; $636,071 on teaching and field instruction, welfare scholarships and fellowships; $215,815 on national agency projects; and $737,984 on welfare demonstration and general welfare projects, including provincially administered bursary and staff development programs. See Table 36.

Subsection 7 - Vocational Rehabilitation

The federal-provincial vocational rehabilitation program, which began in 1952, was consolidated and extended under the Vocational Rehabilitation of Disabled Persons Act, 1961. Agreements under this Act provide for equal sharing of costs between the federal government and the provinces. These costs include co-ordination and provision of services to disabled or other vocationally disadvantaged individuals, training of rehabilitation personnel, and research and publicity. Approved services, supplied by a provincial government or purchased from voluntary agencies by a provincial government, include medical, social, and vocational assessment, intensive counselling, restorative services, the provision of prostheses, vocational training or educational upgrading, rehabilitation allowances, work conditioning, and provision of tools, books, and other equipment.

TABLE 36 - FEDERAL EXPENDITURES UNDER THE NATIONAL WELFARE GRANTS PROGRAM, BY PROVISION AND PROVINCE, YEAR ENDED MARCH 31, 1970

Province	Welfare service plans(a)	Welfare demonstration projects	Welfare research	Teaching and field instruction(b)	Welfare scholarships(c)	Welfare fellowships(c)	National voluntary welfare agency projects	Totals
	$	$	$	$	$	$	$	$
Newfoundland	4,015	-	-	8,102	3,880	-	-	15,997
Prince Edward Island	4,146	15,985	-	-	2,331	-	-	22,462
Nova Scotia	5,575	26,156	34,953	37,527	2,479	-	-	106,690
New Brunswick	15,639	-	-	10,000	1,808	-	-	27,447
Quebec	-	69,908	121,943	-	23,492	17,899	-	233,242
Ontario	138,047	87,684	38,725	243,472	26,433	38,294	-	572,655
Manitoba	-	94,820	15,301	65,511	3,425	-	-	179,057
Saskatchewan	5,972	39,261	9,849	-	3,795	-	-	58,877
Alberta	4,000	70,140	1,778	54,408	-	8,196	-	138,522
British Columbia	30,194	51,389	65,188	65,657	5,465	13,897	-	231,790
Yukon Territory	15,232	-	-	-	-	-	-	15,232
Northwest Territories	59,822	-	-	-	-	-	-	59,822
Not classified(d)	-	-	46,933	-	-	-	215,815	262,748
Canada	282,642	455,342	334,671	484,677	73,108	78,286	215,815	1,924,541

(a) Require a matching contribution of provincial and/or municipal funds.

(b) By location of school.

(c) By home address of recipients.

(d) Amounts payable to national voluntary welfare agencies for projects and for welfare research.

Employment counselling and placement are provided through Canada Manpower Centres of the Department of Manpower and Immigration or by the voluntary agencies from which services are purchased.

In each participating province a provincial co-ordinator or director of rehabilitation is responsible for the co-ordination and administration of services to disabled or vocationally disadvantaged persons. The federal aspects of the program are administered by the Manpower Utilization Branch of the Department of Manpower and Immigration in co-operation with the Department's five regional offices. The Manpower Utilization Branch, through its section on Older Workers, also has the function of encouraging a more favourable employment climate for older workers through a continuing educational program, encouragement of research, maintenance of liaison with management, labour, and voluntary agencies, the assembly and dissemination of informational material concerning industrial gerontology, and supportive services to the Canada Manpower Centres. Among other agencies contributing to vocational rehabilitation are the Workmen's Compensation Boards in all provinces, which provide for the rehabilitation of injured workmen.

In the year ended March 31, 1969, federal expenditures under the program totalled $3,680,000. Reports were received on 3,066 disabled or vocationally disadvantaged persons rehabilitated during the year. Records indicate that of the 3,066 handicapped persons reported as vocationally rehabilitated, 2,224 were rehabilitated to employment and 842 were still seeking employment or were rehabilitated to self-care at home at the close of the fiscal year. Of the 2,224 who obtained employment, the cost of their support and that of their dependents before rehabilitation was estimated at $2,000,000 annually. Following rehabilitation, their aggregate earnings were estimated at almost $8,800,000.

Subsection 8 - National Council of Welfare

Co-ordination in welfare matters between government and voluntary authorities is facilitated by the National Council of Welfare, a citizen's advisory body to the Minister of National Health and Welfare. It is responsible for advising the Federal Minister on such matters related to welfare as it deems appropriate as well as to consider matters referred to it by the Minister. Prior to January 1970, the Council had been mainly a governmental body presided over by the federal deputy minister with the deputy ministers of welfare of each of the provinces

included among its members, but it has been reconstituted as a citizens' advisory council and its terms of reference have been broadened.

The Council now consists of 21 private citizens, approximately half of whom have been selected from organizations of consumers of welfare services and the remainder from institutions which are involved, directly or indirectly, in providing welfare services.

Section 3 - Provincial Welfare Programs

Major welfare programs governed by provincial legislation are social assistance, services for the aged, and child welfare services. Also, the province of Quebec operates the Quebec Pension Plan, which is comparable to the Canada Pension Plan (see p. 63), and a family allowance program (see p. 120). Provincial departments of public welfare are responsible for the administration of welfare programs, although responsibility for a number of the programs may be shared with their municipalities.

Public services are supplemented by those of voluntary agencies whose interests include the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Welfare councils and social planning councils contribute to the planning and co-ordinating of local welfare services. Local voluntary agencies and institutions may receive public grants, depending on the nature and standard of their services, although their main support is usually from united funds or community chests, or from sponsoring organizations.

Subsection 1 - Social Assistance

All provinces make legislative provision for assistance to persons in need and their dependents. All provinces have now incorporated provisions for allowances to needy mothers with dependent children in a broadened program of provincial allowances to several categories of persons with long-term need or in a general program under which the only eligibility requirement is need, irrespective of the cause of need.

Allowances are generally determined on the basis of a needs test under which the allowance granted is the budget

deficit, or the difference between the amount required to meet the applicant's need as determined according to a schedule of rates covering the various budget items of basic need (food, clothing, personal requirements, shelter, fuel, and utilities) and any income available to him to meet that need. All provinces also provide allowances for items of special need; for example, special diets on medical recommendation, special clothing, and expenses incidental to education or obtaining employment. Assistance may also take the form of maintenance in a home for special care or welfare services (see section on Canada Assistance Plan).

The provincial departments of welfare have regulatory and supervisory powers over municipal administration of social assistance and require certain standards as a condition of provincial aid. Length of residence is not a condition of aid in any province, but in those provinces where municipal residence is a factor, the residence of the applicant determines the financially responsible authority. Assistance to persons without municipal residence or persons living in unorganized territory is the responsibility of the provincial authority. Under the terms of the Canada Assistance Plan, all provinces have agreed that residence shall not be a condition of assistance for applicants who move from one province to another.

Social assistance is administered by the province or by the municipalities with substantial financial support from the province, which in turn is reimbursed by the federal government under the Canada Assistance Plan for 50 per cent of the provincial and municipal assistance given, and for certain other costs (see section on Canada Assistance Plan). The formula for provincial-municipal sharing of costs is determined by the province, and varying arrangements are made for the administration of assistance.

As authorized under the terms of the Canada Assistance Plan, a number of provinces have elected to assist needy persons who are disabled or blind under their general assistance programs rather than under the federal-provincial programs for these particular categories of needy persons (see section on Canada Assistance Plan). By mid-1970 six provinces -- Newfoundland, Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, and Alberta -- had discontinued receipt of applications under the disabled persons allowances program. Three of these provinces -- Ontario, Saskatchewan, and Alberta -- had also discontinued applications under the blind persons allowances program.

In Newfoundland all assistance is administered provincially. In Prince Edward Island, the province is responsible for the costs of assistance and services to all needy persons with no requirement for a financial contribution from the municipalities. Assistance is administered by the province, two municipalities and two welfare bureaus.

In New Brunswick, the Department of Health and Welfare administers social assistance under a comprehensive program. In Nova Scotia, the province administers aid under the Social Assistance Act to needy mothers and foster mothers, disabled persons, dependent fathers, needy women 60-65 years of age, and supplemental allowances to recipients of blind persons allowances. The municipalities administer assistance to other needy persons and are reimbursed by the province for at least 75 per cent of the costs of assistance, services, and administration.

In Quebec, the province administers aid to needy mothers under the Needy Mothers Assistance Act and aid under the Quebec Public Charities Act to persons with long-term need: disabled persons whose disability is likely to last more than 12 months, needy widows of 60 years of age or more, recipients of federal or provincial categorical payments or allowances who require supplemental aid. The municipalities administer short-term aid, but the cost of such aid is borne by the province. The Social Aid Act, passed in December 1969 and to come into force on proclamation, provides for assistance to all persons in need, including the blind and disabled, under one comprehensive program.

In Ontario, the Family Benefits Act, 1966, provides for provincial allowances to needy mothers with dependent children, dependent fathers, disabled or blind persons, persons 65 years of age or over who are not receiving an old age security pension, needy widows, and certain other categories of women 60 years of age or over. Municipalities administer aid under the General Welfare Assistance Act to other needy persons and are reimbursed by the province for 80 per cent of their expenditures for aid and for 90 per cent of expenditures for aid to persons in excess of 5 per cent of the population in the municipality. The province reimburses counties and municipalities for 50 per cent of the cost of special assistance and of the cost of administration of welfare services beyond a specified base period.

In Manitoba, the Department of Health and Social Services administers aid under the Social Allowances Act to needy mothers with dependent children, to mentally or physically

incapacitated persons whose disability is likely to last for more than 90 days, and to persons unable to support themselves or their dependents because of their age. Financial aid and services to other needy persons are the responsibility of the municipalities which are reimbursed by the province for 40 per cent of the costs of assistance, or at a higher rate if their costs exceed a specified amount. Since April 1, 1967, the province has also reimbursed municipalities for 50 per cent of the costs of administration of welfare services in excess of costs for the base year 1964.

In Saskatchewan, all aid is provided under the Saskatchewan Assistance Act; need is the only criterion of eligibility. The program of assistance and services under the Act is administered by a municipality or by regional offices of the Department of Welfare. Only two municipalities have elected to administer the program. The province bears approximately 95 per cent of the costs of assistance and services granted in municipalities.

In Alberta, the Department of Social Development administers allowances under the Public Welfare Act to needy mothers with dependent children, to persons who are mentally or physically handicapped for a period likely to last for more than 90 days, and to persons who because of their age are not able to be self-supporting. The Department maintains two hostels and one welfare centre to care for unemployable single homeless men without municipal residence. Aid to other needy persons is administered by the municipalities, which are reimbursed by the province for 80 per cent of the assistance given. Also, under the Preventive Social Services Act, 1966, designed to encourage municipalities to sponsor programs to prevent dependency and family breakdown, the province reimburses a municipality for 80 per cent of the costs of administration of material aid given needy persons under the Public Welfare Act, and for 80 per cent of the municipal expenses in connection with the establishment, operation and administration of certain preventive social service programs.

In British Columbia, the Department of Rehabilitation and Social Improvement administers supplemental allowances to needy recipients of Old Age Security pensions, blind and disabled persons' allowances. Aid to other needy persons is administered under a comprehensive general program by the municipalities, or by the province in areas without municipal organization. Municipalities are reimbursed by the province on a pooled basis for 80 per cent of the total cost of social assistance. Also, the province shares equally with the municipalities expenditures on salaries of social workers; a municipality with fewer than 15,000 persons may arrange to have

the Department undertake social work within the municipality and reimburse it at the rate of 60 cents per capita per year.

Subsection 2 - Living Accommodation for Elderly Persons

In all provinces, homes for the aged and infirm are provided under provincial, municipal, or voluntary auspices. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. The provinces contribute to the maintenance of needy persons in homes for the aged, either through general assistance or through statutes that relate particularly to these homes. Also, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal government (see p. 94).

All provinces in varying degrees make capital grants toward the construction of homes, and in some provinces capital grants are also available to municipalities, charitable organizations, or non-profit corporations for the construction of low-rental housing.

Newfoundland maintains a home for the aged and infirm at St. John's and pays part or all of the cost of maintaining needy old people in homes for the aged and boarding homes. Provision is made for grants to organizations constructing homes for the aged. The Senior Citizens (Housing) Act, 1960 provides for the construction of hostels or housing for the elderly by non-profit corporations. The province guarantees the cost of operating such projects. In Prince Edward Island the Department of Welfare operates five separate institutions and a wing in each of the mental hospital and tuberculosis sanatorium for the care of the aged and infirm. Two charitable organizations also provide special institutional facilities. In Nova Scotia, the aged are cared for in municipal or county homes, in homes operated by religious or private organizations, and in private boarding homes. The province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial government are subject to provincial inspection. In New Brunswick provincial grants may be made under the Senior Citizens Housing Act to assist non-profit housing corporations in constructing and equipping low-rental housing units for senior citizens. Similarly, grants to construct homes for the aged and nursing homes are available under the Auxiliary Homes Act. Homes for the aged are operated under public, charitable, and private

auspices. Voluntary and proprietary homes are subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act. Under the Social Welfare Act, 1966, the province contributes to the maintenance of needy persons in licensed nursing homes and homes for the aged.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Aged Couples Homes Act authorizes the province to erect and maintain homes for aged couples, or to make agreements (including the provision of grants) for their erection, upkeep, and administration with persons, societies, and corporations, public or private. Standards established for homes for the aged are in accord with the regulations under the Public Health Act.

Under the Homes for the Aged and Rest Homes Act in Ontario municipalities must provide institutional or special home care (private family living or foster home care) for the aged; they may also establish rest homes for the care of handicapped persons who cannot be properly cared for at home, in existing homes for the aged, hospitals, or other institutions. The province contributes 50 per cent of the costs of construction of approved homes and 70 per cent of their operating and maintenance costs. It also pays 70 per cent of the costs of maintenance for approved special home care up to a maximum of $140 per month. Homes for the aged under voluntary auspices are approved, inspected, and assisted under the Charitable Institutions Act. This Act provides for construction grants up to $5,000 per bed and for maintenance grants of 80 per cent of the amount spent by the organization up to $9 per day for each resident. The Nursing Homes Act, 1966 established mandatory provincial licensing of nursing homes by the Department of Health for the first time. The Elderly Persons' Housing Aid Act provides for grants to non-profit housing corporations building low-rental housing for elderly persons.

Under The Elderly and Infirm Persons' Housing Act in Manitoba, construction grants equalling one-third of the costs of constructing or of acquiring and renovating housing accommodation and homes for the aged are given to municipalities and charitable organizations. Grants may not exceed $1,700 for one-person housing units, $2,150 for two-person housing units, $2,000 per bed for new homes for the aged, and $1,000 per bed for homes that have been renovated. Under the Social Allowances Act the province bears the entire cost of allowances to those who, because of age, physical or mental ill health, or physical or mental incapacity, require care for more than 90 days by another person or in an institution or home for the

aged and infirm. Institutions and boarding homes for the aged and infirm are supervised and licensed by the Department of Health under public health legislation.

In Saskatchewan, aged and infirm persons are cared for in four provincial geriatric centres, three under the jurisdiction of the Department of Welfare and one under that of the South Saskatchewan Hospital Centre, and in municipal, voluntary, and proprietary homes for the aged. The latter are inspected and licensed under the Housing and Special-care Homes Act. This Act also empowers the province and municipalities to subscribe to the capital stock of non-profit housing corporations building low-rental accommodation for older persons; the province may also make loans to municipalities to assist them in subscribing. Also, the province may guarantee the costs of operation of hostel-type accommodation with common dining and sitting rooms for aged persons. Capital grants amounting to 20 per cent of construction costs are available for self-contained housing projects; similar grants for special-care homes (that is, nursing homes, supervisory-care homes, or sheltered-care homes) may be made to municipalities, churches, or charitable organizations sponsoring approved homes. Further, an annual maintenance grant of $12 per bed is paid to such homes. Costs of maintaining needy persons in homes for the aged are shared by the province and the municipalities under the Saskatchewan Assistance Act.

Under what are termed "master agreements", Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councillors in their membership; net costs of operation are borne by the municipalities. Aside from contract nursing homes, which come under specific legislation, and certain nursing homes under the supervision of the Department of Health, the Welfare Homes and Institutions Branch of the Department of Social Development is responsible for the licensing of and the maintaining of standards in homes for the aged and infirm.

A home for elderly homeless men is operated by the Department of Rehabilitation and Social Improvement in British Columbia. Boarding homes or institutional facilities for the care of the aged and infirm may be provided under municipal, non-profit or proprietary auspices. The province licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Citizens' Housing Aid Act, the province makes grants amounting

to one-third of construction costs to municipalities, regional districts, and non-profit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Subsection 3 - Recreation Centres for Elderly Persons

Ontario gave impetus to the provision of recreation centres for older people through its Elderly Persons' Social and Recreational Centres Act, 1961-62. In 1966 the Elderly Persons Centres Act was passed to replace the earlier legislation. The new Act continues the arrangement for a provincial grant of up to 30 per cent of the cost of constructing or buying a building for use as a recreational centre if the municipality contributes 20 per cent. In addition, provision is made for maintenance grants and special grants for services, facilities, and research.

Subsection 4 - Child Welfare Services

Child welfare services, which include child protection and care, services for unmarried parents, and adoption services, are provided in all provinces under provincial legislation. The programs are administered by the provincial authority or by local children's aid societies (voluntary agencies with boards of directors, operating under charter and under the general supervision of provincial departments). In Newfoundland, Prince Edward Island, New Brunswick, Saskatchewan, and Alberta, child welfare services are administered by the province; in Quebec they are administered by recognized voluntary agencies and institutions, religious and secular; in Ontario, a network of local children's aid societies is responsible for the services; in Nova Scotia, Manitoba, and British Columbia, services are administered by local children's aid societies in the heavily populated areas and by the province elsewhere.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas they also receive support from private subscriptions or from community chests or united funds. The cost of certain services and maintenance for children in care of a voluntary or public agency are sharable with the federal government under the Canada Assistance Plan (see p. 94).

Child welfare agencies, provincial or voluntary, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proved, the court may direct that the child be returned to his parent or parents, under supervision, or be made a ward of the province or a children's aid society. Services are provided as appropriate and include services to children in their own homes, care in foster boarding homes or adoption homes, or, for children who need it, in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Adoptions, including those arranged privately, number about 18,000 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and emphasis is increasingly being placed on group-living homes. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, is of particular significance. Institutions for children are governed by provincial child welfare legislation and by provincial or municipal public health regulations; they are generally subject to inspection and in some provinces to licensing. Sources of income may include private subscriptions, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother and possibly to the father, legal assistance in obtaining support for the child from the father, and foster-home care or adoption services for the child. Support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers are established only in the larger centres. These are chiefly under voluntary auspices, except in Ontario, where there are also municipally sponsored day nurseries operated with the aid of provincial grants.

Subsection 5 - Newfoundland's Schooling Allowances Program

The province of Newfoundland introduced its Parents Supplement (Schooling Allowances) Program in 1966. Under this scheme, an annual benefit of $15 is paid in semi-annual instalments for each eligible child who is registered at and attending a school other than a trade school or university. There is no age limit specified in the legislation but the allowance terminates when the child leaves school.

Subsection 6 - The Province of Quebec's Family Allowances Program

The province of Quebec introduced its own family allowances program under legislation enacted in 1967. Under this plan, the following allowances are paid at the end of each six-month period to persons satisfying the relationship and residence requirements in respect of children under 16 years of age: $15 for one child, $32.50 for two children, $52.50 for three children, $77.50 for four, $107.50 for five, $142.50 for six, and an extra $35 for each child after the sixth. These allowances are increased by $5 for each child between the ages of 12 and 16 years. To qualify for the allowances, children must be attending school regularly from the time when they are first required to do so, unless prevented by physical or mental infirmity. These allowances supplement those paid under the federal scheme.

Section 4 - Emergency Welfare Services

The function of the Emergency Welfare Services Division of the Department of National Health and Welfare is to develop community capability to provide, in the event of a national emergency, essential welfare services not available through the established welfare agencies. A 1959 Order in Council set up five emergency welfare services: emergency clothing, emergency feeding, emergency lodging, registration and inquiry, and personal services, and gave the Division responsibility for the continuation of welfare departments in support of rehabilitation and recovery. To these ends, policy has been defined, systems designed, and, at all levels of government, welfare resources planned.

In peacetime, trained specialists within the federal, provincial, and municipal departments of welfare, organized nationally, are responsible for developing an emergency welfare capability. The program is an integral part of the Canada Survival Plan and is co-ordinated with the programs of other Canadian government agencies, and with mutual support programs of the United States Department of Health, Education, and Welfare. Leaders are being trained in the art of organizing large numbers of volunteers for emergency welfare operations and a public education program is being maintained. Special printed forms and equipment for survival, not regularly available through commercial sources, have been produced and are located strategically across Canada.

Section 5 - International Welfare

Canada is actively involved in the social development activities of the United Nations and its specialized agencies and of various international voluntary organizations. At the United Nations Canada is represented on the Commission for Social Development, is a member of the Executive Board of the United Nations Children's Fund, and actively participates in the International Council on Social Welfare, International Social Security Association, and other international agencies concerned with the social aspects of development.

Under the program of the Canadian International Development Agency, Canada supports a number of social welfare projects in developing regions and provides social-work and social-welfare training for foreign students recommended by their governments. The necessary technical services to the bilateral and multilateral aid programs in this sector are supplied by the Department of National Health and Welfare, which also works closely with several Canadian voluntary organizations engaged in social development.

Section 6 - International Social Security

Canada is in the course of negotiating reciprocal agreements on social security with other countries, commencing with West Germany. Canadian agencies employed in social security participate in the program of the International Social Security Association and the social security program of the International Labour Organization. For some years, Canada has been represented, as an observer, at the meetings of the Inter-American Social Security Association.

PART III - HEALTH AND SOCIAL WELFARE EXPENDITURES

Section 1 - Government Expenditures on Health and Social Welfare

In the seven years ended March 31, 1969, expenditures by all levels of government on health and social welfare rose from $3,689,200,000 to an estimated high of $7,270,000,000, which is close to a two-fold increase. If these figures are adjusted to take account of the growth in population, the increase in per capita expenditures - from $201 to $350 - was about 75 per cent. Government expenditures may also be measured in relation to major economic indicators; on this basis, annual government expenditures on health and social welfare over the 1962-69 period have remained relatively stable, fluctuating between 12.4 and 13.1 per cent of net national income and between 9.2 and 9.9 per cent of gross national product. Table 37 and 38 set out related statistics.

The federal share of health and social welfare expenditures fell from 69.9 per cent in 1961-62 to 60.7 per cent in 1968-69, the provincial share rose from 27.2 per cent to 37.1 per cent, and municipal outlays declined from 2.9 per cent to 2.2 per cent.

Compared with the previous year, 1967-68, health and social welfare expenditures by all levels of government increased by $820,000,000 or by nearly 13 per cent. This may be compared to the rise of $1,066,200,000 or 20 per cent in the previous year over 1966-67. Expenditures in both the federal and provincial fields increased by the same proportion - approximately 12.7 per cent. The main items causing this rise included higher disbursements under the Old Age Security and Guaranteed Income Supplement programs principally because of the lowering of the eligible age and increase in the monthly benefits paid, the greater expenditure incurred by the introduction of the Canada Assistance Plan which is wider in scope than the categorical programs it is intended to replace, higher expenditures under the Unemployment Insurance Act, greater outlays for health and welfare for the Indian and Eskimo populations, expenditures which continue to rise under the Hospital Insurance and Diagnostic Services Act, and contributions to the provinces under the Health and Hospital Construction Grants and the Health Resources Fund Act.

The relative federal declines, compared to provincial gains in recent years, have been caused to a substantial degree

by increasing hospital expenditures by the provincial governments augmented by the effect of the "opting out" arrangements made available to the provinces. Under the Established Programs (Interim Arrangements) Act, a province may choose to receive contributions from the federal government in the form of a tax abatement and an equalization payment in lieu of a direct federal contribution under the program. The opting-out arrangements have the effect in this presentation of showing an increase in provincial government expenditure while the federal fiscal payment is treated not as an expenditure but as a transfer payment. Thus, provincial expenditures include gross outlays by Quebec whereas the federal expenditures on health and social welfare do not include the large sums paid or transferred to that province under the Established Programs (Interim Arrangements) Act and other fiscal arrangements. The share of the federal government in total health and social welfare expenditures by all levels of government showed a steady decline from year to year up to 1967-68. In 1968-69, however, this trend has been reversed.

The proportion of government expenditures on health and social welfare taken up by health programs continues to grow; in 1961-62 such programs accounted for $1,126,000,000 or 30 per cent and by 1968-69 they amounted to $2,779,000,000 or 38 per cent.

An outline of the principal federal income maintenance programs for 1968-69 shows the magnitude of the major programs and services - Family Allowances payments amounted to $560,000,000, Old Age Security payments to $1,297,000,000 plus another $244,000,000 under the Guaranteed Income Supplement program, Unemployment Insurance benefits to $459,000,000 and veterans pensions and allowances to $223,000,000 and $102,000,000 respectively. In addition, payments under the Youth Allowances program, which commenced in September 1964, amounted to $52,000,000 excluding the province of Quebec. That province had instituted a program of schooling allowances three years prior to the introduction of the federal program and this necessitated a special arrangement whereby Quebec continued its program but with appropriate fiscal reimbursement from the federal government. In 1967-68, Quebec inaugurated its own family allowances program supplementing the federal scheme (see page 120).

Federal-provincial income-maintenance programs in 1968-69 required expenditures of $3,400,000 for old age assistance, $2,100,000 for blindness allowances, $6,400,000 for disabled persons allowances and $1,000,000 for unemployment assistance, the latter including some municipal expenditures. The smallness of these amounts indicate the effectiveness of the Canada

Assistance Plan, for which this was the third year of operation and which was intended to replace all activities under these programs at the option of each province (see pp. 96-103). In 1965 Quebec withdrew from these federal-provincial programs under the Established Programs (Interim Arrangements) Act, which entitled that province to a tax abatement and an equalization payment. Canada Assistance Plan expenditures in 1968-69 were $257,000,000. Provincial Workmen's Compensation Boards spent $177,000,000 on cash benefits for pensions and compensation. Welfare services for Indians and for veterans and the national employment services accounted for $104,000,000 at the federal level.

In the field of health, federal grants to the provinces under the Hospital Insurance and Diagnostic Services Act totalled $562,000,000 and grants for hospital construction and general health grants to the provinces and municipalities amounted to $44,000,000. The federal government spent $44,000,000 on its Indian and northern health services and $72,000,000 on hospital and treatment services for veterans. Provincial expenditures on hospital care were estimated at $1,415,000,000 and expenditures on other health services at $350,000,000. In addition, provincial Workmen's Compensation Boards paid $62,000,000 for medical aid and hospitalization, and municipal governments spent an estimated $89,000,000 on health.

Section 2 - Expenditures on Personal Health Care

Expenditures on personal health care reported here comprise expenditures of hospitals, earnings of physicians and dentists for professional services to their patients, and the value of prescription sales through retail pharmacies. They exclude earnings of private nurses, chiropractors, osteopaths, and optometrists for their professional services and expenditures on public health, capital costs (buildings and interest), and administration costs of public-health programs and of insurance plans.

Table 39 shows the components for each year from 1961 to 1969. Canadians spent a total of $3,924.7 million on personal health care in 1969, almost two and one-half times as much as ten years before. Expressed as a proportion of the gross national product, personal health care expenditures rose from 4.1 per cent in 1961 to 4.9 per cent in 1969. Expenditure per person over the same period changed from $86.87 in 1961 to $186.10 in 1969.

TABLE 37 - TOTAL, PER CAPITA, AND PERCENTAGE DISTRIBUTION OF GOVERNMENT EXPENDITURES ON HEALTH AND SOCIAL WELFARE, BY LEVEL OF GOVERNMENT, YEARS ENDED MARCH 31, 1962-69

Year ended March 31	Federal	Provincial	Municipal	Total
	Total Expenditures			
	$'000,000	$'000,000	$'000,000	$'000,000
1962	2,577.1	1,004.3	107.8	3,689.2
1963	2,683.5	1,097.7	117.3	3,898.5
1964	2,801.0	1,166.8	101.2	4,069.1
1965	2,969.7	1,376.1	108.2	4,454.0
1966	2,833.5	1,714.3	129.6	4,727.4
1967	3,243.1	2,002.5	127.0	5,383.8
1968(a)	3,915.5	2,426.6	138.5	6,450.0
1969(a)	4,413.5	2,698.5	158.0	7,270.0
	Per Capita Expenditures			
	$	$	$	$
1962	140.34	54.69	5.87	200.90
1963	143.44	58.68	6.27	208.39
1964	146.95	61.22	5.31	213.48
1965	152.92	70.86	5.57	229.35
1966	145.80	86.68	6.56	239.04
1967	160.88	99.90	6.30	267.08
1968(a)	190.55	116.61	6.74	313.90
1969(a)	212.76	130.08	7.62	350.46
	Percentage Distribution			
1962	69.9	27.2	2.9	100.0
1963	68.8	28.2	3.0	100.0
1964	68.8	28.7	2.5	100.0
1965	66.7	30.9	2.4	100.0
1966	61.0	36.31	2.7	100.0
1967	60.2	37.4	2.4	100.0
1968(a)	60.1	37.2	2.1	100.0
1969(a)	60.7	37.1	2.2	100.0

(a) Includes or based on estimated data.

TABLE 38 - EXPENDITURES OF ALL LEVELS OF GOVERNMENT ON HEALTH AND SOCIAL WELFARE IN RELATION TO NET NATIONAL INCOME AND GROSS NATIONAL PRODUCT, YEARS ENDED MARCH 31, 1962-69

Year ended March 31	Government expenditures on health and social welfare		
	Amount	Per cent of net national income	Per cent of gross national product
	($ millions)		
1962	3,689.2	12.8	9.6
1963	3,898.5	12.5	9.5
1964	4,069.1	12.2	9.2
1965	4,454.0	12.3	9.2
1966	4,727.4	11.8	8.8
1967	5,383.8	11.5	8.6
1968	6,450.0(a)	12.9	9.7
1969	7,270.0(a)	13.1	9.9

(a) Estimated.

TABLE 39 - EXPENDITURES ON PERSONAL HEALTH CARE, CANADA, 1961-1969

Year	Hospital services					Physicians' services	Dentists' services	Prescribed drugs(b)	Total
	General and allied special hospitals	Psychiatric institutions	Tuberculosis sanatoria(a)	Government of Canada(a)	All hospitals				
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1961	722.1	134.9	28.2	63.9	949.0	388.3	116.7	133.6	1587.6
1962	811.8	144.4	27.6	70.3	1054.2	406.1	121.5	141.0	1722.8
1963	909.8	163.0	28.3	73.8	1174.9	453.4	136.9	156.6	1921.9
1964	1015.1	182.1	26.2	76.8	1300.2	495.7	147.8	170.9	2114.6
1965	1144.5	211.6	26.0	79.8	1461.9	545.1	160.1	200.0	2367.1
1966	1319.0	241.8	25.9	82.1	1668.8	605.2	176.4	214.6	2665.0
1967	1523.0	283.9	26.0	83.3	1916.3	686.2	187.2	239.5	3029.1
1968(c)	1779.2	319.8	27.0	90.4	2216.4	788.1	213.7	258.2	3476.5
1969(c)	2036.8	350.9	29.1	96.3	2513.1	910.0	231.4	270.1	3924.7

(a) Tuberculosis sanatoria of the Government of Canada are included under the latter heading only.

(b) Sold by retail drugstores only.

(c) Estimates, except data for "Physicians' services" for 1968, which are final.

Section 3 - Earnings of Privately Practising Physicians in Canada

The average gross professional earnings of fee-practising physicians in 1968 were $42,783, as shown in Table 40. This figure was 10.6 per cent higher than in 1967 and 65 per cent above the 1961 figure. The highest average gross earnings in 1968 were reported in Alberta, at $51,894. In Ontario and Newfoundland they were above the national average. Average gross incomes in the remaining provinces ranged from $41,848 in British Columbia to $32,584 in Prince Edward Island.

Generally, through the eight-year period 1961-68, average gross earnings have been at a higher level in Newfoundland, Ontario, and the western provinces while grouped at a somewhat lower level in Quebec and the maritime provinces.

The net returns to physicians, after deduction of the expenses of professional fee practice, reveal similar geographic patterns, as seen in Table 41. Net earnings for Canada as a whole averaged $28,615 in 1968. This figure was 9.7 per cent higher than in 1967 and 74 per cent above the 1961 figure. The highest provincial average net income from professional practice was reported by Alberta physicians at $33,221 followed by Ontario physicians at $32,098. The lowest provincial average net income, $22,636, was reported for Prince Edward Island.

Section 4 - Number of Physicians in Canada

In December 1969 there were 29,659 active civilian physicians in Canada. Over a third, 11,201, were located in Ontario. British Columbia had the lowest population/physician ratio, 653, followed by Ontario with 676 and Quebec, 706. The national average at December 1969 was 717 persons per physician.

Table 42 gives the provincial distribution and population/physician ratios for 1969 and shows also the historical trend in the national total since 1901. The figures include all junior and senior interns and residents, and physicians engaged in administration, teaching, research, etc., within the medical field, as well as those in the clinical practice of medicine.

TABLE 40 - AVERAGE GROSS PROFESSIONAL EARNINGS(a) OF ACTIVE FEE-PRACTICE PHYSICIANS, CANADA BY PROVINCE, 1961 TO 1968

Province	1961	1962	1963	1964	1965	1966	1967	1968
	$	$	$	$	$	$	$	$
Newfoundland(b)	27,184	24,809	27,903	30,630	31,620	33,688	36,503	43,256
Prince Edward Island	20,001	19,676	23,413	23,157	25,596	26,284	28,720	32,584
Nova Scotia	23,242	23,302	23,455	25,739	27,486	29,960	30,391	35,820
New Brunswick	24,220	23,978	26,376	27,802	29,622	30,271	35,891	38,933
Quebec	22,118	23,418	25,748	26,813	29,010	30,901	33,455	36,187
Ontario	27,206	27,779	30,641	33,201	35,752	38,254	42,721	47,427
Manitoba(c)	29,072	29,003	28,769	29,103	32,037	33,589	36,657	40,083
Saskatchewan	27,103	23,238	35,657	36,484	37,474	40,150	40,150	41,546
Alberta	29,221	31,187	30,912	32,690	35,397	37,871	43,819	51,894
British Columbia	27,867	27,498	27,670	30,510	31,675	36,063	38,609	41,848
Yukon and Northwest Territories(d)	20,083	20,081	22,007	16,495	27,812	22,900	25,750	36,850
Canada	25,862	26,322	28,690	30,586	32,799	35,223	38,675	42,783

(a) Includes gross professional fees, and earnings received in the form of wages and salaries for professional services.
(b) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1968 was 104.
(c) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1968 was 59.
(d) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 41 - AVERAGE NET PROFESSIONAL EARNINGS(a) OF ACTIVE FEE-PRACTICE PHYSICIANS, CANADA BY PROVINCE, 1961 TO 1968

Province	1961	1962	1963	1964	1965	1966	1967	1968
	$	$	$	$	$	$	$	$
Newfoundland(b)	18,640	18,042	19,455	21,523	23,028	23,304	25,578	30,488
Prince Edward Island	13,119	15,448	15,777	16,478	17,835	18,910	20,716	22,636
Nova Scotia	16,070	15,925	15,839	17,851	19,146	20,395	21,480	24,642
New Brunswick	16,288	16,418	17,701	19,255	20,251	20,807	24,662	27,544
Quebec	14,454	15,173	16,696	18,534	20,532	21,231	23,133	25,112
Ontario	17,682	18,306	20,492	22,247	24,188	25,456	29,354	32,098
Manitoba(c)	15,829	16,742	18,178	18,720	19,681	21,565	23,229	26,108
Saskatchewan	15,843	14,619	21,625	23,879	23,530	24,274	24,697	25,175
Alberta	17,925	18,612	19,111	21,117	22,681	24,356	27,591	33,221
British Columbia	17,067	17,284	17,464	19,560	20,121	22,209	25,169	26,239
Yukon and Northwest Territories(d)	15,594	16,368	16,480	13,601	15,731	13,039	13,200	18,000
Canada	16,472	16,970	18,688	20,484	22,064	23,262	26,093	28,615

(a) Includes net professional fees after deducting expenses of practice, and wages and salaries for professional services.
(b) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1968 was 104.
(c) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1968 was 59.
(d) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 42 - PHYSICIANS AND POPULATION PER PHYSICIAN, 1901-69, AND BY PROVINCE, 1969

Source, Year, Province	Active Civilian Physicians	
	Number	Population per Physician
Census data(a)		
1901 (June 1)	5,475	972
1911 "	7,411	970
1921 "	8,706	1,008
1931 "	10,020	1,034
1941 "	10,723	1,072
1951 "	14,325	976
1961 "	21,290	857
D.N.H. & W.(b)		
1962 (Dec. 31)	23,248	808
1963 "	24,082	795
1964 "	24,847	785
1965 "	25,481	779
1966 "	26,528	763
1967 "	27,544	749
1968 "	28,163	744
1969(c) "	29,659	717
1969(c)		
Newfoundland	428	1,206
Prince Edward Island	94	1,170
Nova Scotia	971	788
New Brunswick	578	1,078
Quebec	8,500	706
Ontario	11,201	676
Manitoba	1,353	723
Saskatchewan	1,129	840
Alberta	2,129	744
British Columbia	3,242	653
Yukon	16	1,000
Northwest Territories	18	1,833
CANADA	29,659	717

(a) Figures for 1901 to 1951 exclude Yukon and Northwest Territories.

(b) Estimates for 1962 to 1968 for interns and residents, based on Dominion Bureau of Statistics data, and for other active civilian physicians based on the data of List Catalogue, Canadian Mailings Limited. (Seccombe House).

(c) Produced by the Department of National Health and Welfare from information supplied by Medical Marketing Systems Limited. (Seccombe House).

PART IV - NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, medical research, and education. These agencies, some of which are described below, complement the services of the federal and provincial authorities in many fields, and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Arthritis and Rheumatism Society. - This agency, organized in 1948 with head office in Toronto, provides research, treatment, and education in rheumatic diseases. It has assisted many general hospitals to establish arthritis clinics, and during 1960-1970 has supported the development of nine rheumatic disease in-patient units in teaching hospitals in five provinces. Organized under eight provincial divisions and local branches in most towns, this organization attempts to meet any special needs of arthritis patients not covered by hospital or medical insurance plans.

The Arthritis Centre in Vancouver, opened in 1969 by the Society, provides an up-to-date comprehensive program of services to ambulant patients. It employs new evaluative techniques in occupational therapy and physiotherapy, combined clinical assessment of patients by surgeons, physicians, and other members of the treatment team, and improved follow-up programs, which measure the effectiveness of treatment. The Centre also serves as an education unit for health service personnel, including occupational therapists, physiotherapists, nurses, medical students, physicians and resident staff.

The Canadian Arthritis and Rheumatism Society provides home physiotherapy in larger cities, and mobile consultation services to patients and doctors in rural areas. The regular Canadian Conference on Research in Rheumatic Diseases is promoted by the Society.

The Society estimates that by 1974 it will have spent $1,700,000, or 45 per cent of its budget, on research and the operation of rheumatic disease units, which are emphasized as the keys to control of arthritis. Of a budget amounting to $2,350,000 in 1968, one-quarter was directed to research and the support of rheumatic disease units, and 55 per cent was directed to the provision of treatment services. Public donations are the chief source of funds, including independent campaigns and the United Appeal.

The Canadian Association for the Mentally Retarded. - (prior to 1968, The Canadian Association for Retarded Children). - Incorporated in 1958 to co-ordinate the work of organizations serving the mentally retarded, estimated to amount to three per cent of the population, or 630,000 persons, the Association is represented by ten provincial and over 300 local groups. It offers special classes and sheltered workshops for trainable retarded children and adults, assessment clinics, activity centres, summer camps, and other recreational programs. Its affiliate, the National Institute for Mental Retardation, is a clearinghouse for information on mental retardation and, in co-operation with other organizations and with governments, is developing a nation-wide research and demonstration program.

Over 300 staff members of sheltered workshops and activity centres and other community care workers attended 28 short training courses between September 1968 and April 1969. Another widely publicized event in the 1969 program was the Canadian Special Olympics for the Mentally Retarded held in Toronto.

Financial support comes from local fund-raising campaigns, United Appeals, the sale of special Christmas cards (over two million cards in 1968), and in varying degree from provincial and municipal governments, including departments of education. The national office is in Toronto.

The Canadian Cancer Society. - This agency, with the active encouragement of the Canadian Medical Association, was organized as a cancer study unit and incorporated in 1938. It operates in all provinces from its national office in Toronto. It offers public education and services not otherwise available for cancer patients, principally transportation, home nursing, boarding and nursing home care, sickroom supplies and dressings. Research into the causes and treatment of cancer has expanded and in 1970 accounted for $4,062,629, over 50 per cent of the expenditure of the Society. The Society is the principal fund raiser for its affiliate, the National Cancer Institute of Canada, and in fact provided more than 90% of the Institute's 1969 budget of over $4 million. The Canadian Cancer Society also sponsors fellowships in cancer research for advanced students and provides capital funds for research facilities.

The Canadian Cystic Fibrosis Foundation. - This national agency, organized in 1960, with head office in Toronto, now operates in most provinces, and has 30 affiliated local chapters. Because cystic fibrosis is believed present in one of every 1,000 babies born in North America, the Foundation seeks to promote special services for patients, and research, professional

training, and public understanding concerning cystic fibrosis. A valuable source of publicity and research funds has been the annual "Shinerama" in which 40 Canadian colleges and universities participated in 1969, raising $120,102. In addition to its services in Canada, the agency also supports the International Association composed of 22 member nations.

The Canadian Diabetic Association. - The Association, formed in 1953 with headquarters in Toronto, has 38 branches established in nine provinces, and a French-language affiliate, l'Association du Diabète, in Quebec. It is also affiliated with the Canadian Medical Association and the Canadian Dietetic Association. Its aims are to co-ordinate the efforts of individuals and organized bodies with a view to reducing the morbidity and mortality rates from diabetes, and to provide an authoritative and advisory organization for the benefit and service of diabetics.

The Association estimates that one-fortieth of the population is diabetic, but that less than half of the diabetics are aware of their illness. The Canadian Diabetic Association seeks through its public information programs to help diabetics identify their illness at an early stage. One method in current use is a multi-screening technique that simultaneously tests for the presence of diabetes, tuberculosis, anemia, and glaucoma. The Association also provides diet counselling, summer camps for children, aid to diabetic senior citizens, education and information services, and diabetic treatment centres. Research into the nature and treatment of diabetes includes the Family Tree Research Program. The Association also publishes a quarterly bulletin, the Canadian Diabetic Association Newsletter.

The Canadian Hearing Society. - Organized in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society has offices in Toronto, Ottawa, London, Hamilton, and Montreal. It is concerned with the preservation of hearing, the treatment of deafness, and the rehabilitation of those with impaired hearing, including war veterans and children. It provides hearing examinations, counselling, vocational guidance, and job placement services for the deaf or hard-of-hearing, and hearing aids to persons in need. It also works closely with schools for the deaf. The Society publishes The Canadian Hearing Review and other educational material available for the public.

The Canadian Heart Foundation. - The Canadian Heart Foundation with headquarters in Ottawa was formed by physicians in 1956 "to co-ordinate and correlate the efforts of organizations

and individuals interested in heart diseases with a view to reducing the morbidity and mortality therefrom in Canada." It has developed into a federation of six affiliated provincial heart foundations together with four provincial divisions of the Canadian Foundation in the Atlantic provinces. Their programs are concerned primarily with the support of cardiovascular research in Canadian universities and hospitals. Over 70 per cent of the resources of the Foundation are disbursed in the form of research and fellowships and grants-in-aid amounting to $15,000,000 in the past ten years and over $2,500,000 in 1969-70. They also support travelling lectureships by scientists, and educational programs for the health professions and the general public. The chief source of funds is the annual Canadian Heart Fund campaign.

The Canadian Medic-Alert Foundation. - This international association had its beginnings in California in 1956. The Canadian affiliate was organized in 1961, with its head office in Toronto. The main purpose of the Medic-Alert Foundation International is to educate and encourage the public to wear Medic-Alert identification discs stipulating medical problems that should be known of in an emergency, and to encourage doctors and nurses to advise persons of the importance of wearing such identification.

The Foundation estimates that one person per family has a medical problem, such as sensitivity to certain drugs, a heart condition, diabetes, epilepsy, or uncommon blood type. A recently added feature is the identification of the bearer as a possible transplant-donor. The wearing of the disc enables such a person to receive correct treatment if, for example, he reaches hospital unconscious. The medical history of each disc-wearer (i.e., member) is filed in Toronto and in Tuloch, California; discs carry emergency telephone numbers through which this information can be obtained at any hour.

Canadian membership is currently estimated at 40,000, with seventy per cent of new members being referred by their family physicians. The Foundation is financed by lifetime membership fees, seven dollars at the present time, and by donations. The Life Underwriters Association of Canada sponsored an educational campaign for the Foundation in 1970.

The Canadian Mental Health Association. - The national body, established in 1918 and legally incorporated in 1927, has its head office in Toronto, divisions in all provinces, and nearly 200 local branches and committees.

The national office is financed by United Appeals, government grants, support from provincial divisions, and donations. The Association's objectives are to improve public understanding of and attitudes toward mental illness and the mentally ill, and to improve existing preventive and treatment services. It points out that the Dominion Bureau of Statistics estimates that one in every eight Canadians will be treated for psychiatric illness during their lifetime.

The C.M.H.A. performs research and technical studies related to mental illness, undertakes social and community action to improve legislation and governmental programs, conducts industrial rehabilitation workshops, provides volunteer services to patients both during and after their stay in hospital, and provides public and professional education about mental health and mental illness. Among special services provided by volunteers are the 42 White Cross Centres, social clubs designed to assist former patients who have difficulty coping with a feeling of social isolation. Recreational activities are supplied through four summer camps for patients.

The C.M.H.A. administers the C.M. Hincks Research Fund which enables general practitioners to take a month of special training in psychiatry. Publications resulting from research studies that the C.M.H.A. has sponsored include More for the Mind, The Law and Mental Disorder, Mental Health and Public Health, and University Student Unrest.

The Canadian National Institute for the Blind. - This agency was incorporated in 1918 "to carry out all operations which shall be deemed advantageous throughout Canada for the welfare of the blind" and "to take measures and adopt every possible means for the conservation of sight". To this end, services are provided through a national office in Toronto, eight divisions covering all provinces, and 50 subdistrict offices. United Funds and private donations are the major sources of income.

In 1969, services were provided to 21,291 of the 27,184 blind persons registered with the Institute, including educational and vocational assistance, home teaching and employment, eye services, mobility training, recreation, special services to children and youths, and social services. Services provided to 8,175 other persons registered as "prevention" cases included eye examinations, medical treatment, glasses or artificial eyes, transportation, and maintenance. Services are provided free to those in need of assistance.

The Institute also supports the operation of the Arthur V. Weir Training and Vocational Guidance Centre for advanced professional and technical training in Toronto and Low Vision Aid Clinics and Eye Banks in major cities. The Canadian National Institute for the Blind does not directly conduct research programs, but supports research through the E.A. Baker Foundation, and provides funds for grants, bursaries, and fellowships (some $43,000 in 1968) to be used for training of professionals in blindness prevention. The National Library of the Institute is continually expanding its disc and tape talking-book library.

The Canadian Paraplegic Association. - The Association was formed in 1945 by a group of paraplegic veterans of World War II to assist with the re-establishment of paraplegics in the community. Through its head office in Toronto, and its seven divisions serving other areas in Canada, the Association seeks to ensure provision of adequate treatment and rehabilitation facilities, including prostheses and personal aids, for any persons suffering paralysis caused by disease or injury. The Association also carries out educational research activities in related areas.

The Canadian Paraplegic Association provides a comprehensive treatment service at Lyndhurst Lodge Hospital in Toronto; elsewhere it arranges for these services with other hospitals and rehabilitation agencies.

The divisional offices have led local campaigns to remove architectural barriers that deny access to public buildings to paraplegics and other handicapped persons. Such barriers hamper the physically handicapped in using community services and facilities and reduce their opportunity for vocational rehabilitation and employment. To overcome these difficulties, the National Research Council published "Building Standards for the Handicapped, 1965" as Supplement to the National Building Code. It is estimated that one in seven Canadians will have to cope with this problem at some period, as a result of temporary disability, age, or physical handicap. A stylized wheelchair symbol was adopted at the 1969 World Congress of the International Society for the Disabled to designate buildings that are accessible to the handicapped.

The Canadian Paraplegic Association is supported primarily by public donations, but also by grants from United Funds and federal, provincial, and municipal governments, and fees from patients. The agency publishes a regular information bulletin, Caliper.

The Canadian Red Cross Society. - The Canadian Red Cross Society, established in 1896, is the largest voluntary organization operating in the fields of health and welfare. In line with its objectives, "in time of peace or war, to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world," the Society operates 22 programs including a national blood-transfusion service, hospital and nursing stations in isolated areas (34 in 1968), home nursing, homemaker, and sick-room supply-services, and the Red Cross Youth programs which seek to promote understanding of and assistance to needy children everywhere.

The Red Cross blood-transfusion service held over 6,500 clinics in 1968. In addition, the Society is a member of the international rare-blood donor service; of the 340 donors called upon for donations by that service in 1968, 139 were Canadians. Welfare recipients were provided with instruction in nutrition, purchasing, and basic sewing in addition to home nursing service. Women's work programs shipped $488,000 of new clothing and layettes to 24 countries in 1968, and articles of clothing and surgical dressings were provided to Red Cross hospitals in Canada. Red Cross Youth programs assisted needy Canadian children at a total cost of almost $200,000 in 1968. Funds were donated to provide medical treatment, heart surgery, prosthetic appliances, dental care including provision of three mobile dental coaches and support of eight dental clinics, speech therapy, and kindergartens for the deaf. In addition, international youth programs extended assistance to children in other countries, totalling some $120,000 in 1968. The Red Cross as a whole extended overseas aid amounting to one and a half million dollars in 1968. Included were the shipment of a number of prefabricated buildings to earthquake areas in Sicily, clothing and layettes, food and medical aid, and operation of a service which helps to reunite families separated by war or other emergencies.

Chief source of funds for the work of the Canadian Red Cross are United Appeals, government grants and the annual Red Cross Campaigns.

The Canadian Rehabilitation Council for the Disabled. - This agency was founded in 1962 by the merging of the Canadian Foundation for Poliomyelitis and the Canadian Council for Crippled Children and Adults. The Rehabilitation Council promotes co-operation among agencies assisting the rehabilitation of disabled persons, such as the national agencies for cerebral palsy, hemophilia, and cystic fibrosis and the provincial councils for the disabled. The Rehabilitation Council offers consultative services, public education and training courses,

and seminars for rehabilitation workers. Its head office is in Toronto. The Council is affiliated with the International Society for Rehabilitation of the Disabled and the Canadian Medical Association. Its official publication is the Rehabilitation Digest.

In the smaller provinces the two founding organizations have merged their programs. However in British Columbia, Ontario, and Quebec, separate societies for handicapped children continue to administer case-finding, restorative, and related services including parent counselling, camping, and recreation financing the programs by Easter Seal campaigns. The foundations for the disabled in these same three provinces, financed by the March of Dimes or community chests, provide services to disabled adults, with more emphasis upon vocational rehabilitation, including the establishment of sheltered workshops.

The Canada Safety Council. - This organization was established in 1968 by the merger of three previously separate organizations, The Canadian Highway Safety Council, The National Safety League of Canada, and The Canadian Industrial Safety Association, in order to unite all phases of safety education. The head office of the Council is in Ottawa. Its goal is to prevent accidents and thereby save lives and reduce injury and suffering. The Council estimates that over 11,000 Canadians die accidentally each year, and that hundreds of thousands are seriously injured.

It provides training courses related to safety, such as driver training, defensive driving, high school driver education, and baby-sitter training. Public education projects include Safe Driving Week, Fire Prevention Week, Child Safety Week, Farm Safety Week, safety-belt campaigns, car-check campaigns, and pedestrian-cyclist safety campaigns.

Funds are obtained from federal and provincial government grants, business and industry, national labor organizations, provincial motor leagues, and automobile associations.

The Canadian Tuberculosis and Respiratory Disease Association. - This agency was founded in 1900 for "the prevention of consumption and other forms of tuberculosis in Canada." Along with its medical arm, the Canadian Thoracic Society, established in 1960, the Association has extended its work in recent years to cover all respiratory illnesses. The national office in Ottawa and the 10 provincial and numerous local branches co-operate with public health agencies in promoting special programs including public and professional

education, prevention, diagnosis, treatment and rehabilitation. The Association also makes consultant services available to federal and provincial health departments.

The case-finding program of the Association is carried out at the local level using mass X-ray screening surveys directed in particular at high-rish groups. In addition, some of its mobile X-ray units now employ multi-screening techniques for a number of health problems, including diabetes.

In the fields of research and professional education, the Society estimates that it distributes $300,000 annually and that a further $184,000 is provided by provincial associations. It also gives active support to the International Union against Tuberculosis for programs in underdeveloped countries where tuberculosis is a serious problem.

The Canadian Welfare Council. - Established in 1920, the Council seeks to give leadership on matters concerning the social welfare of Canadians. Member organizations include community funds and councils, other private social agencies, various federal, provincial, and municipal departments, and citizen groups and individuals active in the fields of health, welfare, and recreation. It furnishes information, technical consultation, and field services in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies. It directs attention to changing social needs and proposes new policies and services in these areas. Through public education programs, it informs the public and political bodies on problems, policies, and objectives of social welfare services including health programs.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. With professional staff assuming executive functions, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, Community Funds and Councils, and Aging, and through special committees.

The Council's current research studies include the first Canadian survey of visiting homemaker services and a national study of day-care centres for children. The Council publishes the periodicals Canadian Welfare, Bien-Etre Social Canadien, The Canadian Journal of Corrections, and a directory of Canadian Welfare services. Funds to support its programs are mainly derived from United Appeals, membership fees, general donations, and government grants.

The Health League of Canada. - This agency was established in 1919 as the National Committee for Combatting Venereal Disease. The League is dedicated to the education of the Canadian public on matters of public health, both in prevention and in early recognition of disease, thereby improving the health standards of Canadians. It has dealt with immunization, fluoridation of water, gerontology, nutrition, and child and maternal health. In 1952, it was appointed the Canadian Citizens' Committee of The World Health Organization. The League publishes the magazine Health, which contains articles by professional health workers, and sponsors National Health Week and National Immunization Week. It is financed by government grants, voluntary donations, and membership fees. In co-operation with its affiliates in Quebec City and Montreal, the League administers its programs from the national office in Toronto.

The Multiple Sclerosis Society of Canada. - The Society was organized in 1948, to support medical research into the causes and treatment of multiple sclerosis. In 1968-69 its research expenditures reached $103,000, a record high. Through its head office in Toronto and five divisions and local chapters located in ten provinces, the Society attempts, in co-operation with other agencies serving the disabled, to meet the special needs of patients with multiple sclerosis. A survey in Toronto in 1968 demonstrated that these needs, as expressed by the patient and his family, were often more social than financial. To improve services to patients several Ladies' Associations for Multiple Sclerosis have been organized, and some local chapters have begun patient registries. This agency also provides public education and information services, including the quarterly bulletin Multiple Sclerosis.

Funds for support of its programs come from bequests and grants, donations, United Appeals, and various other projects such as the sale of Multiple Sclerosis Christmas cards and Hallowe'en candy.

The Society is a member of International Federation of Multiple Sclerosis Societies, which now has 18 member-organizations. Through this affiliation, research projects are co-ordinated and information on new developments is exchanged.

The Muscular Dystrophy Association of Canada. - This Association was organized in 1954 to increase knowledge of muscular dystrophy, to improve facilities for diagnosis and treatment, and to foster research into muscular dystrophy to develop a more successful treatment. The national office is

in Toronto and there are local chapters located in 15 major cities. It estimates that over 10,000 Canadians have muscular dystrophy, of whom about one-quarter are enrolled with the Association. It supports seven muscular dystrophy clinics, limited physiotherapy, certain orthopedic devices and wheel chairs, and transportation to schools and clinics. It is giving increasing emphasis to genetic counselling services.

The major source of revenue is the independent campaigns carried out with the assistance of local firemen. Some help also comes from the United Appeals and grants from municipal and provincial governments. The bulk of the funds of the Association go into grants for medical research. Seventy studies were assisted in 1968-69, both in Canada and abroad, at a total cost of $715,544.

The National Cancer Institute of Canada. - This agency was organized in 1947 to support and co-ordinate research on cancer, promote professional education in cancer, compile and interpret cancer statistics, and assist in the co-ordination of provincial cancer control programs.

Full-time research positions for over 30 scientists have been established, while capital grants to six universities have facilitated the construction of laboratory space for cancer research. Of the total annual budget, 90 per cent (or about $3,800,000 in 1970) is allocated to research, while most of the remainder provides training in cancer research.

Under an agreement with the Canadian Cancer Society, with which it is affiliated, the Institute does not publicly appeal for funds. Its main sources of income are the Canadian Cancer Society and federal and provincial grants for cancer control.

The St. John Ambulance Association. - The Order of the Hospital of St. John of Jerusalem held its earliest recorded first aid course in Quebec in 1883. Incorporated on a national basis in 1914 with headquarters in Ottawa, the organization operates through 10 provincial Councils and seven "Special Centres". The Order is composed of two sections - the St. John Ambulance Association, and the St. John Ambulance Brigade. The objectives of the Association are to provide training in first-aid, home nursing, and child care, in 1969 reaching 130,000 trainees. The Brigade provides emergency services to the public through uniformed volunteer members numbering 12,000 in 1969.

Courses of instruction are made available to the general public, police, firefighters, industry, the armed forces, schools, civil defence, and youth organizations. The emergency

services provided include two-way radio equipment, emergency oxygen supplies, motor boats and underwater gear, ski and snowshoe patrols, and highway first-aid-posts. The two-hour "Save-A-Life" program teaches artifical respiration methods to an estimated 150,000 persons annually. Bursaries to nurses in training have amounted to $36,000 in the past seven years.

Funds are obtained from private donations, United Appeal campaigns, the sale of text books and other publications, and fees for training government personnel. Publications include The St. John News, films, and radio and television scripts. In 1969, the Association received $900,000 from the general public, industry, and various levels of government, in support of its work.

The Victorian Order of Nurses. - The basic function of this organization, created in 1897, is to provide nursing services in the home. In 1970, the V.O.N. directed 16 co-ordinated home care programs and participated in 11 additional such programs by supplying either the nurse-administrator or the nursing service. Through 107 branches located in all provinces except Prince Edward Island, these services are made available to an estimated 60 per cent of the population of Canada, to anyone in the community regardless of age or financial status and one a 24-hour basis, for acute, chronic, or convalescent patients.

In 1968, a total of 109,151 patients were assisted, of whom the majority were medical and surgical patients, the rest being maternity patients and newborn infants. A sick-room-supply loan service is also provided. As a result of a number of factors including escalating hospital costs, bed shortages, and the preference for home care on the part of the elderly, the Order predicts an increase in its medical and surgical patients.

Other services are offered according to local needs, in shared programs with other agencies, or in demonstration programs. The Victorian Order of Nurses has co-operated, when requested, in the establishment of services related to home care, such as housekeeping, home help, and meals on wheels. Additional services may include school health clinics, immunization clinics, classes for expectant parents, and part-time nursing services to small industries.

Funds for the organization come from a federal grant, the Community Chest, donations, membership fees, and an annual campaign. The national office is located in Ottawa.

PART V - UNIFORM LEGISLATION GOVERNING PRIVATE PENSION PLANS

The enactment of the Canada and Quebec Pension Plans emphasized the need for uniform private pension legislation across Canada. Ontario amended the Ontario Pension Benefits Act with effect from July 30, 1965, and Quebec enacted the Supplemental Pension Plans Act with effect from July 15, 1965. The Pension Benefits Act of Alberta came into force on January 1, 1967, and that of Saskatchewan was assented to on April 1, 1967. The provincial legislation governs all pension plans operating on and after the effective date in the particular province. Similar legislation at the federal level, the Pension Benefits Standards Act, was assented to on March 23, 1967, and is applicable only to those pension plans having members employed in works, undertakings, and businesses (generally, banks and interprovincial transportation and communication) that are under federal jurisdiction.

Under these Acts, basic standards have been established with which pension funds or plans organized and administered to provide a pension benefit to employees must comply in order to receive registration, and they are not allowed to operate in these provinces or in the federal areas of responsibility unless they have received registration.

By agreement, each of the provinces mentioned above recognizes similar legislation of the others, so that a pension plan that has been registered and reports in one province does not have to seek registration or duplicate all its reporting procedures in another of these provinces if it extends its operations to employees in that other province.

The legislation requires that an employee's benefits under a pension plan become fully vested (i.e., he has full entitlement to those benefits, which will be paid to him on retirement) when he reaches age 45 and has completed either a minimum of ten years of membership in a pension plan or ten years of service with the one employer. Moreover, should the employee leave his job or resign his membership in the plan prior to retirement, at least 75 per cent of his total benefits under the plan must be locked-in for purposes of his pension, allowing him to withdraw no more than 25 per cent of the commuted value of those benefits in a lump sum. These rules apply as from the qualification date established under the legislation or from the date the plan was established if it commenced operations after the qualification date.

Other provisions of this legislation are intended to ensure the full solvency of these pension plans within a specified period of time, to restrict the types of investments which may be made by the pension fund, to provide that an employee's pension rights are portable if he should change his job, and to establish that each interested party to a pension plan is adequately informed as to the provisions of the plan.